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ABSTRACT

Part of a series of studies designed to lead to policy recommendations to improve mental health services to Mexican Americans in Texas, this monograph explores the availability and accessibility of community mental health centers (CMHCs) throughout the state. In hopes of explaining the underutilization of the centers statewide, the locations of CMHCs in relation to the Mexican American and Anglo population clusters are plotted and the major highways connecting the populations and the centers are traced. Because of the heavy concentration of the state's population in five major metropolitan areas (Houston, Dallas, San Antonio, Fort Worth, and El Paso), a second description of CMHCs in these cities is given in an effort to determine whether ethnicity affects accessibility to the centers. A series of questions examines: (1) locations of services; (2) relation of population clusters to CMHCs; (3) accessibility to the greatest number of people; and (4) locations of centers in relation to Mexican American neighborhoods. Conclusions suggests that statewide accessibility from Mexican American regions to CMHCs is poor; the metropolitan accessibility is somewhat better, but there are hints of a tendency to locate centers in the middle class Anglo neighborhoods. It is suggested that this preliminary study should generate more research into the reality of this descriptive archival research. (Author/JD)

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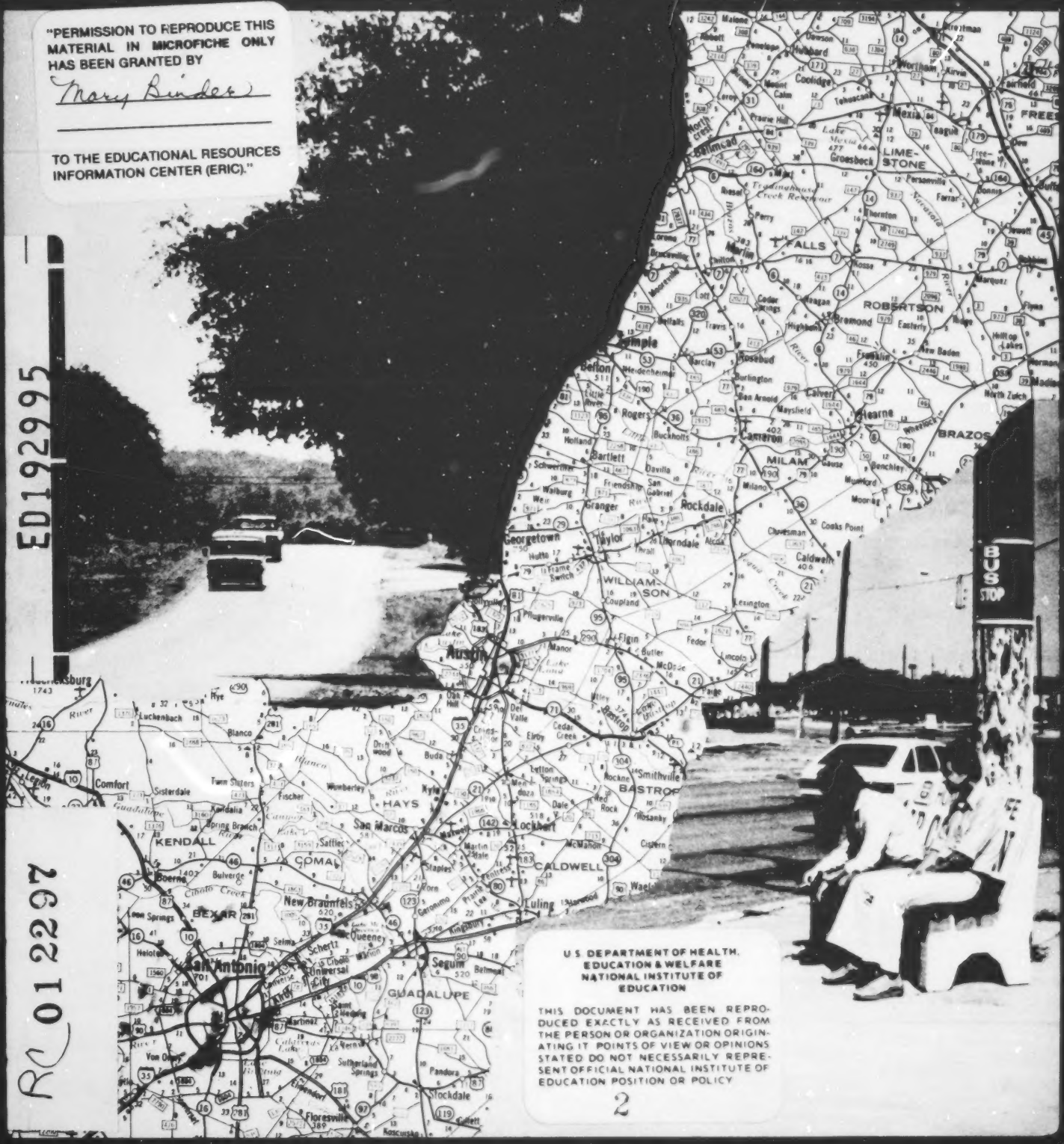


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# The Location of Community Mental Health Centers in Texas: Some Descriptions and Comparisons

by

Ramiro Valdez, Ph.D.

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This publication was produced with funds from a grant (MH 31212-02) made to the Intercultural Development Research Association (IDRA), by the National Institute of Mental Health (NIMH). However, the opinions expressed herein are solely those of IDRA and do not necessarily reflect the position or policies of NIMH, and no official endorsement should be inferred.

# THE LOCATION OF THE COMMUNITY MENTAL HEALTH CENTERS IN TEXAS: SOME DESCRIPTIONS AND COMPARISONS

## (ABSTRACT)

The location of the community mental health centers in Texas are plotted on maps of the state, as well as the location of the Anglo population clusters, the Mexican American population clusters, and the major highways connecting the populations and the centers. The statewide description indicates that accessibility from the Mexican American regions to the community mental health centers is poor. A second description of the mental health centers in Houston, Dallas, San Antonio, Fort Worth, and El Paso indicates that accessibility is somewhat better for urban Mexican Americans, but there are hints of a tendency to locate the community mental health centers in the middle class Anglo neighborhoods. This preliminary study calls for and should lead to further studies to determine the reality of this descriptive archival research.

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Thanks are also due to Juan Luis Tercero for his drawing of the graphics, to Janice Pape for her research and editing help, and to Rosario Trejo for her quick typing and patient support. Thanks to each of you!

## MENTAL HEALTH RESEARCH PROJECT OF THE INTERCULTURAL DEVELOPMENT RESEARCH ASSOCIATION

The Intercultural Development Research Association's Mental Health Research Project (MHRP), funded by the National Institute of Mental Health, seeks to improve mental health delivery systems for Mexican Americans in the state of Texas.

The MHRP's major goals include: 1) a preliminary analysis of the effectiveness of the state mental health service delivery system and subsystems in providing services to Mexican Americans; 2) an assessment of the community mental health center concept as it relates to the Mexican American population; 3) the design of a bilingual/multicultural human service delivery model relevant to the mental health needs of Mexican Americans in Texas; and 4) the development of policy and programmatic alternatives to enhance the utilization of the state mental health service delivery system by Mexican Americans.

The MHRP has established a Texas Advisory Committee which consists of mental health service deliverers, professionals/academicians and consumer representatives from the five major geographical regions of Texas. The committee members serve as conduits for information dissemination and collection. To ensure maximum generalizability of the process and products of the MHRP, six nationally recognized professionals in the area of mental health and service delivery systems serve as consultants to the MHRP in the form of a National Advisory Committee.

The goal of the IDRA Mental Health Research Project is improved services for Mexican Americans in the state of Texas. Because a lack of agreement has existed in Census surveys and social science research as to the definition of a "Mexican American," potential problems emerge in attempting to compare data sources across regions or time frames. Terms encountered historically to identify this ethnic group include: Mexicans, Mexican Americans, Spanish-surnamed, Spanish-speaking, Latin Americans, Spanish Americans, Hispanics, etc. The term "Mexican Americans" is used consistently by the Mental Health Research Project to refer to this population, indicating those residents who are of Mexican origin or descent. References to specific data sources may at times utilize the exact label cited therein (e.g., "Spanish Americans"); it is assumed by the project that the overwhelming majority of any such individuals in Texas are of Mexican origin.

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# INTRODUCTION

The intent and design of the Mental Health Research Project is to do exploratory research into community mental health services to Mexican Americans in Texas. By looking at such things as staffing, funding, and utilization of services at the local community mental health centers (hereinafter referred to as CMHCs or "the centers") throughout the state, it is hoped that a concise description of current services will generate a clearer definition of service delivery problems, resulting in action towards a solution of these problems. While there is clearly a need for expanded and sophisticated research in mental health services to Mexican Americans in Texas, the goals of this project are more exploratory and descriptive, hoping to lay a solid foundation for the much needed further research.

Other monographs already produced by IDRA have described staffing patterns, board memberships, and utilization practices at the CMHCs in Texas. None of these are considered finalized so that addendums may yet be made to them. The findings thus far indicate an overrepresentation of Mexican Americans in the lower echelons of employment, an underrepresentation of Mexican Americans in the boards of directors of the CMHCs, and inconclusive evidence regarding utilization (some centers are underutilized by Mexican Americans, while others are not). It is planned that all of these monographs be seen as working papers still to be finalized, concerted and integrated into a major work leading to substantive policy recommendations when the project nears completion.

This monograph, following in the footsteps of the others, will merely explore the situation and do some basic comparisons. It is intended to plot the locations of the CMHCs throughout the state in relation to the Mexican American population. In other words, the present study will plot the CMHCs, plot the Mexican American population in the state, and consider the ease with which commuting between the two can be carried out. This will involve some description of major arteries of transportation in rural locations and public transportation in the urban centers. Comparisons will be descriptive and not investigative.

A curious phenomenon frequently observed by mental health researchers is that those people who predictably would most need mental health services are often the ones to least use them. The lower socioeconomic classes, the ethnic minorities, immigrant groups, etc., have been found by other researchers to underutilize services so often that the existence of this phenomenon is seldom questioned. While there may be a widespread acceptance of the theory of underutilization, there is a scarcity of solid explanations for its existence. Clearly, if services are not available, they will not be used. Further, if services are not accessible, i.e., inconvenient to get to because of their location or routes one must travel to reach there, they will not be used. Finally, services may be unacceptable to the clientele in that their needs are not met or the price they must pay (financially, emotionally, culturally, etc.) to have them met is too great.

This monograph will focus on the accessibility of CMHCs to the Spanish-language/Spanish-surname (hereinafter SL/SS) populations. An effort will be made to determine whether or not the CMHCs can be easily reached by the SL/SS. Not intended to result in any concrete answers at this time, this monograph will probably raise more questions than it will answer - by intent.

If it can be determined that the CMHCs are accessible to the Mexican American population, yet the services are still underutilized, there is an indication of some other reason besides poor accessibility for this phenomenon. In other words, if CMHCs are not only available, but also accessible, then it is necessry to explore within the walls of the center itself or the client population for an explanation.

The broad, general question this paper will attempt to answer is whether or not mental health services at the CMHCs are accessible to the Mexican Americans residing within the state's region; more succinctly, is there an association between ethnicity and accessibility. Ethnicity in this case is the independent variable and accessibility is the dependent. It is the supposition of the author that ethnicity affects accessibility rather than the converse, but there may be any number of intervening variables that could account for an effect so that the design calls for an association, rather than an effect.

The results of this monograph, when placed alongside others produced by the Mental Health Research Project should give the reader an excellent overview of the situation in Texas as far as

mental health services to Mexican Americans. This study alone, while interesting to consider, cannot in and of itself provide enough information for the goals of the Mental Health Research Project to be achieved, but can contribute significantly. It is important to bear in mind that this present study is part of a series, and its fullest meaning and potential can only be achieved when considered as part of the whole.

It essence, this study will not focus on the availability of services. While such a study could be justified, considering that there may be areas in the state wherein there may be no mental health services to the Spanish-speaking at all, it seems preferable at this point to focus on describing what exists rather than carping about what could or should exist. Further, the existence of Spanish-speaking therapists and personnel will be analyzed in yet another study.

This study will not focus on acceptability of services either. While these three factors (availability, accessibility and acceptability) in mental health services are seldom analyzed singularly, this study will focus on the accessibility of services, and contribute to the overall picture of availability, accessibility and acceptability of services, to be finally drawn by this project.

## METHOD

The major concern of this study, whether or not there is an association between ethnicity and accessibility, will be divided into two major Regional Research Questions with four pattern questions to each. The two major Regional Research Questions in reality are one question divided so as to enhance the descriptions. The first will cover the state of Texas as a whole, and the second will cover the five major metropolitan areas in the state. Formally stated, the Regional Research Questions are:

Regional Research Question Number One: Are mental health services at the CMHCs throughout the state accessible to the majority of the Spanish-language/Spanish-surname populations residing in that particular region of the state?

Regional Research Question Number Two: Are mental health services at the CMHCs in the five major cities in Texas accessible to the Spanish-language/Spanish-surname population clusters within those cities?

The reason for dividing the question is that the state's population is almost equally divided in this way, considering that approximately 45% of the state's population resides in the five major metropolitan areas. Thus, it seems practical and reasonable to divide the state into, more or less, major metropolitan areas and the remainder of the state. Also, the five major metropolitan areas all have their own CMHC system within their boundaries, due to the size of their populations. Further,

communication lines within the cities, as well as transportation systems, support systems, and perhaps even the incidence of psychopathology and manifest symptoms thereof, may differ from other regions of the state. In other words, there are enough differences between the five major cities and the rest of the state to warrant the division.

Pattern Questions. A series of questions will be answered for each of the two Research Questions; the same questions for each. Specifically, where are the services located? These will be plotted on a map of the state and on maps of the five cities. Secondly, in relation to the CMHCs, where are the population clusters located? Are the CMHCs located where they provide greater accessibility to the greatest number of people? Have they located in those neighborhoods from where their clientele are most likely to hail? Or have they located in some place where few people and/or none of their clients live?

Further, where are the CMHCs located in relation to the Mexican American neighborhoods? Granted there may be Mexican Americans living in all parts of the service area, especially in the five major cities, but there are usually neighborhoods that are predominantly Mexican American, often lower class and blighted, in most parts of the state. Have the CMHCs located in proximity to the Mexican American neighborhood? Or are they located instead in a place where it is difficult for the Mexican Americans to get to the CMHC? In addition, if the CMHC is located

near the Mexican American neighborhood, could there be some major impediment, e.g., a major highway with the entrance ramp located several miles down the road, that might prevent potential clients' access to the center?

A final point of interest concerns the measures taken by the CMHCs to make themselves accessible. While there is not always an option as to where centers will locate (they may be in a situation where they will take whatever area they can get), there are measures that can be taken to make themselves accessible, such as proximity to bus lines and main transportation arteries. The investigation also will examine this area. Granted, an inquiry as basic as this will not determine with finality every effort being made by the local CMHC to be accessible. However, there are certain highly visible measures that are sometimes taken that even an initial analysis such as this can determine.

Assumptions. There are several assumptions that precede this investigation. First, it will be assumed that all centers are in active compliance with the law, particularly PL 94-63 and its stipulations for bilingual services. This includes the Texas State House Bill 3 and the Commissioner's Rules of the Texas Department of Mental Health and Mental Retardation. The state laws do not require bilingual services, but federal laws do.

It will also be assumed that services are equal at all centers. That is, one may expect to receive basically the same reception and treatment as well as the same psychiatric care from one center to the next. While it is clear that there are many

variables that may prevent this from being a reality, the assumption can be made that services generally will be no better from one center to the next as far as in-house services. This should make the principle variable of effect the accessibility factor rather than the services factor. As stated before, other monographs of the Mental Health Research Project will investigate services; this one will make assumptions about services and focus on accessibility.

An assumption must be made regarding public transportation services. This assumption is that the services are adequate and acceptable. It is common knowledge that public transportation is sometimes undesirable. There are instances when the same company will provide a transportation service that is excellent on one particular route while quite poor services are provided on an adjacent route. This has sometimes been associated with ethnic or economic factors. However, for the purposes of this study, it will be assumed that services are acceptable to all.

A similar assumption is that Mexican Americans are accepted equally at all centers, once the Mexican Americans are inside the centers' doors. In other words, it shall be assumed that the probable reason that any Mexican American who requires psychiatric services and resides in the proper catchment area does not go for treatment is that the center may not be accessible, rather than a dissatisfaction with the services or with the acceptance he finds there. While this acceptance may not be a reality, for the purpose of this study, the assumption shall obtain.

Finally, there are some centers among the 28 that are not affected by PL 94-63 and therefore need not comply with S201 as others do. This law is applicable when there are Mexican Americans residing in the catchment area, because PL 94-63 requires bilingual services in those cases. Neither House Bill 3 of the Texas Legislature nor the Commissioner's Rules for MHMR require a center to provide services in a foreign language. While this ruling has little to do with accessibility, it can reflect a center's willingness to serve non-English-speaking populations. If, for example, a center is not required to provide services in Spanish, but does so, it can be said that this center is going the extra mile. However, the present data will not supply us with information as to willingness to serve. It must be assumed, therefore, that all centers are equally willing to provide services to the Mexican Americans who reside in their area, but may be prevented from doing so due to the Mexican Americans' not coming in for services and the Mexican Americans' not coming to the centers because they are not accessible.

Definitions. Those definitions that have been determined for the project as a whole will also apply in this monograph. They will be briefly reviewed.

While the term to be used in any research to describe an ethnic group can often pose a problem, this problem is minimal in this monograph. This is because the U.S. Department of Commerce has already defined the group under the title "Spanish Language/Spanish Surname." This means that the person either speaks the Spanish language or has a Spanish surname. While

there are many good arguments as to why this title is not appropriate, this monograph relies heavily on census tract data put out by the Department of Commerce. Therefore, we must use their title since we are using their data for our description.

A Mexican American is a Spanish language and/or Spanish surnamed American resident of Mexican descent living in the United States. This monograph will use the term SL/SS over others. It is particularly important to notice that the SL/SS definition used in the census shall be seen here in Texas as synonymous to "Mexican American." Granted, there are other Hispanics in this state, but the overwhelming majority of the SL/SS population is Mexican American. We shall concern ourselves with this particular group that represents the largest number. CMHC records may list them as Hispanic, Latin or some other name, but the term Spanish language/ Spanish surname will be substituted for whatever title is used by the CMHC.

A community mental health center is any center ("center" and "CMHC" will be used interchangeably) that is providing mental health services in accordance with PL 94-63 and/or in accordance with House Bill 3 of the Texas Legislature and the Rules of the Commissioner. IDRA's Mental Health Research Project has defined 28 centers in the state as meeting these criteria.

While there may be many definitions for a community mental health center, these 28 have been selected because of their specific provision of services to the psychiatrically impaired. This excludes the mentally retarded, the drug or substance

abusers, alcoholics, etc., from the definition. There are centers that provide services to the mentally ill as well as some of these others, and these have been included. It is only those centers that provide no services at all to the mentally ill that are excluded. This is because of this project's focus on mental health, which excludes mental retardation.

Accessibility is defined as the ease with which clients can get to the center. The most preferable, of course, is that the center be within walking distance, but this cannot be brought about for any but a few clients. Therefore, accessibility shall be determined by two measures. First, is the center easily reached by private auto? Specifically, is it near the main transportation arteries of the community?

Secondly, is the center reachable by public transportation? Do the buses go in and out of that area of the community? If so, how far does one have to walk from the bus stop to the center? If the buses do not run into the community wherein the CMHC is located, do they at least run into the Mexican American community? How many changes and transfers are required to reach the center from the Mexican American community?

These questions, while not exhaustive, should provide enough of an incentive for some interesting descriptions. There are many more questions to be answered regarding service delivery to Mexican Americans at the community level, but these should be seen as the first stage or first glance inquiries that could, at a later time, bring about more questions and eventually more answers.

Thus, Chapter One will consist of a description of the locations of the CMHCs in the state with some basic comparisons between regions of the state regarding accessibility to the SL/SS population. Chapter Two will describe the location and accessibility of the CMHCs in the five largest cities in the state. Chapter Three will come to general conclusions and will include a brief discussion as to the findings.

Due to the descriptive nature of this monograph it is necessary to use a series of maps in order to plot the locations of the centers. Sometimes reproducing maps time and again reduces the clarity of the image. For this reason, a map of the state of Texas, depicting all the counties, has been included in Appendix A, thus serving as a reference if and when the descriptive maps are unclear.

## Chapter One: Descriptions Across The State

Location of CMHCs. The Texas Department of Mental Health and Mental Retardation (hereinafter TDMHMR), in compliance with Public Law 94-63 and House Bill 3 of the Texas Legislature, and their respective amendments, oversees twenty-eight community mental health centers in an effort to meet the mental health needs of its residents. The funding, staffing, service delivery, etc., of the CMHCs can vary widely, but they all have one important factor in common: they are all locally controlled, designed, and highly community-oriented. It was the original intent of the community mental health movement to decentralize services and return them to the community wherein they are needed. Like the rest of the states in the Union, Texas has strived toward meeting that goal.

Map 1 presents a sketch of the CMHCs in Texas and their service areas. In order to determine a center's service area, one must find the dot indicating the center and note the lines surrounding it. For example, the Heart of Texas Region MHMR Center in Waco serves the six counties nearest it: Bosque, Hill, Freestone, Limestone, Falls and McLennan, but not Bell, which is adjacent to the county in which the center is located. Bell County is served by the Central Counties Center for MHMR services in Temple, as are Hamilton, Croyell, Lampasas and Milam Counties.

Upon looking at the map, one cannot help but notice that there are sections of the state not included in any CMHC service area. Those rather salient areas in the southwestern part of the

state and along the semi-arid plains of Big Spring and directly north and northeast, are served by outreach clinics of the state hospitals, or by the state hospitals themselves. While there are indeed services available in these outreach clinics, these are very different from the community-centered CMHCs in other parts of the state. Also, there are vast differences between psychiatric services available at a state hospital and those available at an outreach clinic, the former possibly employing several hundred people and offering all the services of a hospital, the latter probably consisting of a small handful of people who each have several types of duties to perform.

It is indeed good that the state of Texas has 28 community-centered and community oriented CMHCs, but there is still room for improvement in the southwestern part of the state.

The General Population. Map 2 depicts the percentage of the state's total population as contained in each county. In other words, it presents the distribution of the total population. As can be seen, there are fourteen counties that have over one percent of the state's population, but the overwhelming majority have less than .2%. While the more densely populated counties are scattered throughout the state, the majority of them are located along the Population Arch formed by Interstate 35 from Grayson and Cooke Counties south to Bexar County. The other major clusters are the Houston/Galveston/Beaumont area, the lower Rio Grande Valley, and El Paso, Nueces and Wichita Counties. The later three are rather outstanding in that they are not connected

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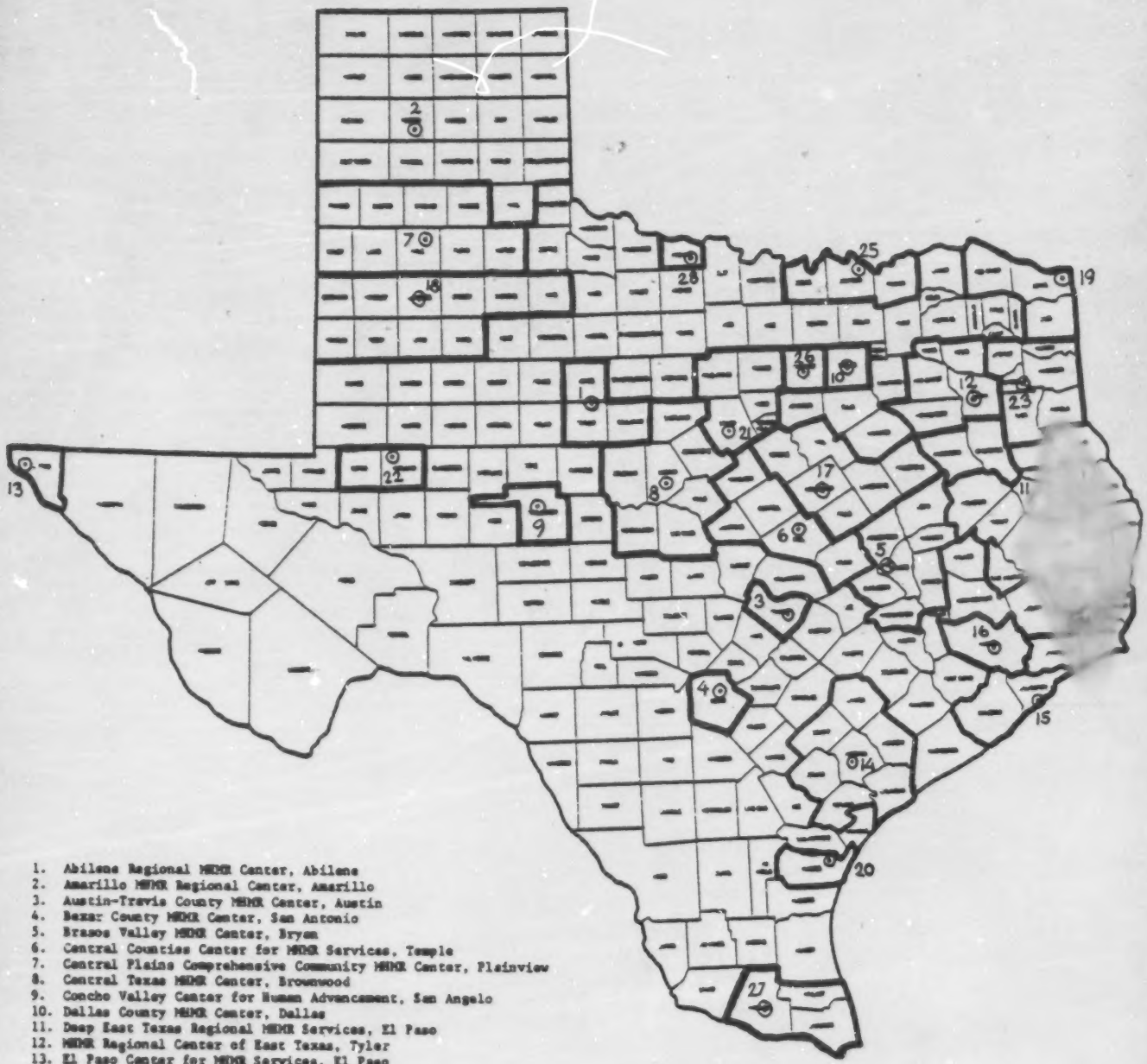
Map 1: The 28 Community Mental Health Centers of Texas and their Catchment Areas, 1978.



1. Abilene Regional MHMR Center, Abilene
2. Amarillo MHMR Regional Center, Amarillo
3. Austin-Travis County MHMR Center, Austin
4. Bexar County MHMR Center, San Antonio
5. Brazos Valley MHMR Center, Bryan
6. Central Counties Center for MHMR Services, Temple
7. Central Plains Comprehensive Community MHMR Center, Plainview
8. Central Texas MHMR Center, Brownwood
9. Concho Valley Center for Human Advancement, San Angelo
10. Dallas County MHMR Center, Dallas
11. Deep East Texas Regional MHMR Services, El Paso
12. MHMR Regional Center of East Texas, Tyler
13. El Paso Center for MHMR Services, El Paso
14. Gulf Bend MHMR Center, Victoria
15. Gulf Coast Regional MHMR Center, Galveston
16. MHMR Authority of Harris County, Houston
17. Heart of Texas Regional MHMR Center, Waco
18. Lubbock Regional MHMR Center, Lubbock
19. Northeast Texas MHMR Center, Texarkana
20. Nueces County MHMR Community Center, Corpus Christi
21. Pecan Valley MHMR Region, Stephenville
22. Permian Basin Community Centers for MHMR, Midland
23. Sabine Valley Regional MHMR Center, Longview
24. MHMR of Southeast Texas, Beaumont
25. Texoma Regional MHMR Center, Denison
26. Trinity Valley MHMR Authority, Ft. Worth
27. Tropical Texas Center for MHMR, Edinburg
28. Wichita Falls Community MHMR Center, Wichita Falls

Source: TDMHMR 1979 Annual Report

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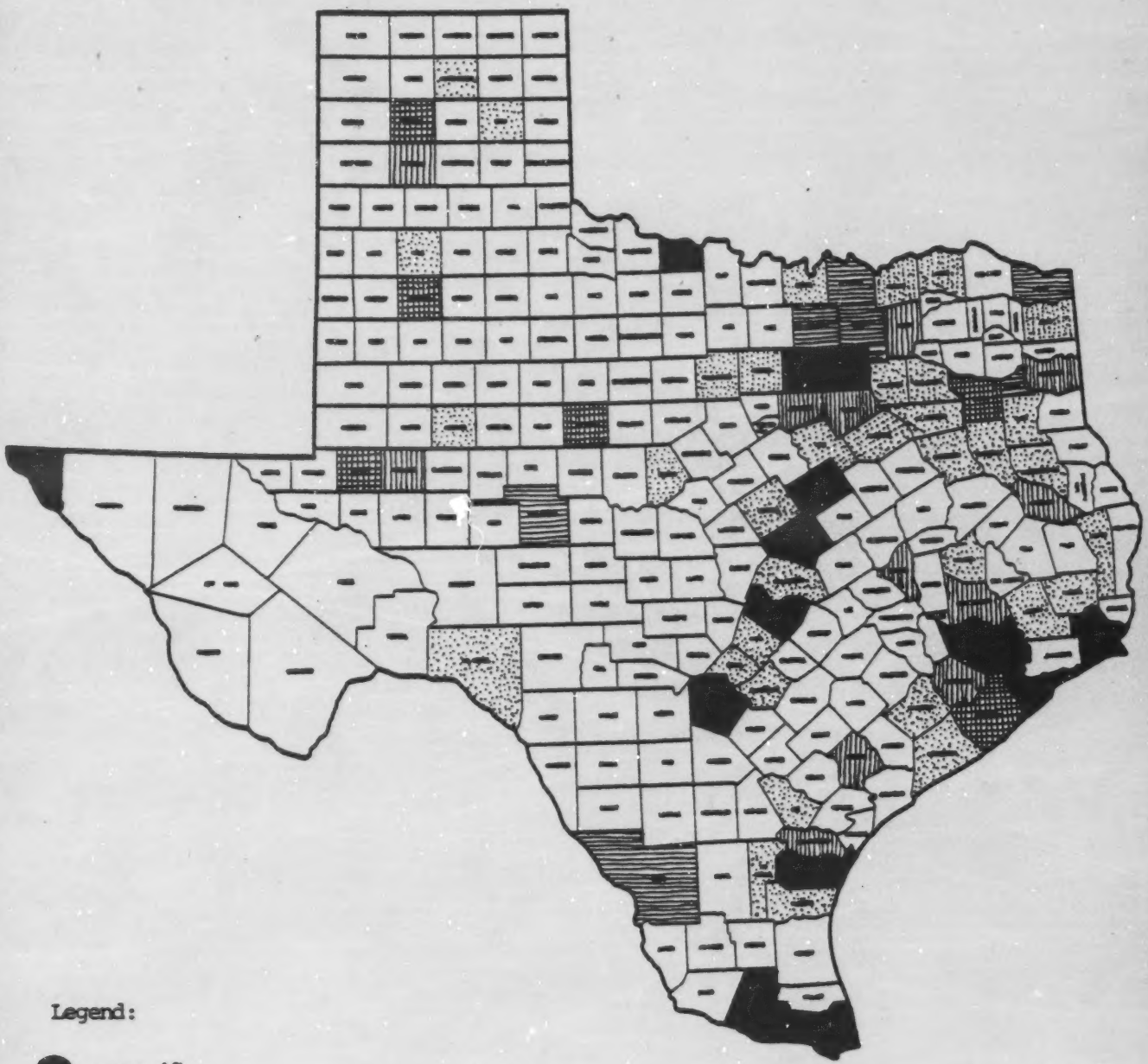
Map 2: Percent of the Total State Population, per County, 1970.



Legend:

- over 1%
- .8 to .99%
- .6 to .79%
- .4 to .59%
- .2 to .39%
- .0 to .19%

Source: U.S. Census Bureau

to any other heavily-populated counties or the thoroughfare of the Population Arch. Most likely, the one large city in each of these counties accounts for the density.

It is further interesting to note that the population seems to cluster in the eastern half of the state. If one were to draw a line from the western border of Wichita County straight south to about Rio Grande City, the overwhelming majority of the population would lie to the east of the line.

The CMHCs and the General Population. It seems reasonable to speculate that the majority of the CMHCs would also lie to the east of the same imaginary line since this is where most of the state's population lies. Map 3 confirms this. The CMHCs form a line along the Population Arch and are scattered along the state's most densely settled areas. It is particularly important to notice that in those cases where there are two densely populated counties adjacent to each other (e.g., Harris/Galveston or McLennan/Bell) there has been an effort made to provide services to each particular county apart from the other - all except for Hidalgo and Cameron Counties. This is the only case where a CMHC for each county has not been provided. Of the fourteen counties in the state that have over one percent of the state's population contained within their boundaries, there is only one that does not have its own CMHC within its boundaries: Cameron County.

Granted that there may be many intervening variables, but on the basis of prima facie evidence, Cameron County is not

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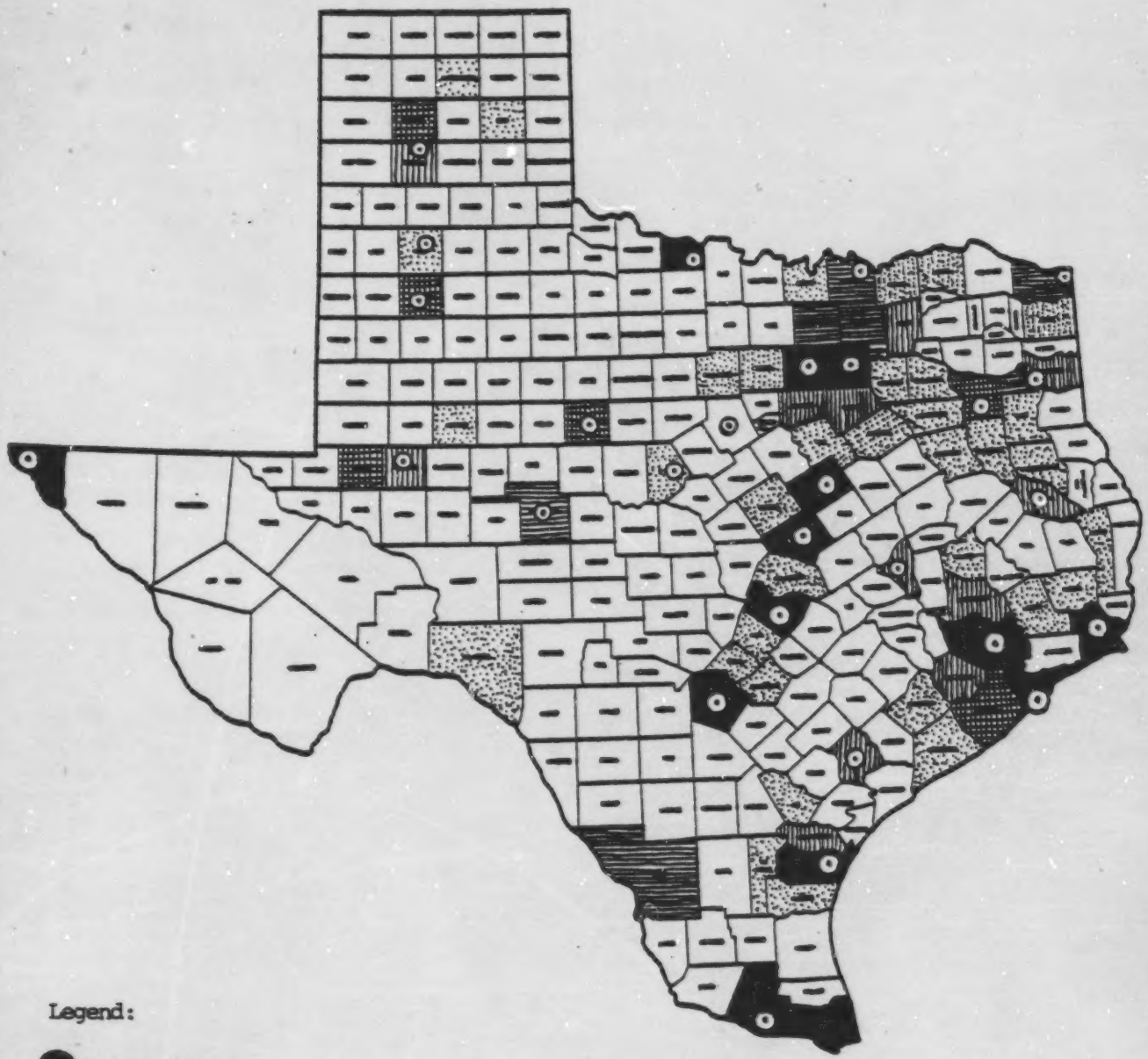
Map 3: The Community Mental Health Centers in Texas and Statewide Population, by County, 1970.



Legend:

- over 1%
- .8 to .99%
- .6 to .79%
- .4 to .59%
- .2 to .39%
- .0 to .19%

Source: U.S. Census Bureau

receiving the same level of mental health services as other counties of comparable populations. There is an outreach clinic from the state hospital in Brownsville so that the county is not totally without psychiatric services. However, an outreach clinic may not compare to a county's having its own community-designed center.

There is, in fact, a CMHC in Hidalgo County, just across the county line from Cameron County so that federally funded bilingual services are available in Edinburg for people from Port Isabel, San Benito, Harlingen and so forth. However, there also exists the possibility that relations between the two counties may not enhance cross-county utilization. The author does not know what the reality of the situation is, but it is often the case that what appears to be very close on a map may be indeed remote in reality; not just in land miles, but in territorialism or rivalry between factions. This fact has not, at this time, been investigated and undoubtedly should be by other studies.

The SL/SS Population. The unique situation of Cameron County becomes even more curious when one considers Map 4. The forth map represents the SL/SS population of the state, by county. Those counties that have more than 70% SL/SS residents are noted by the darker shading. Those counties that have very few SL/SS (less than 5% of the population of the county) are colorless.

A quick glance at Map 4 indicates that the SL/SS population is clustered along the southwestern region of the state. If one

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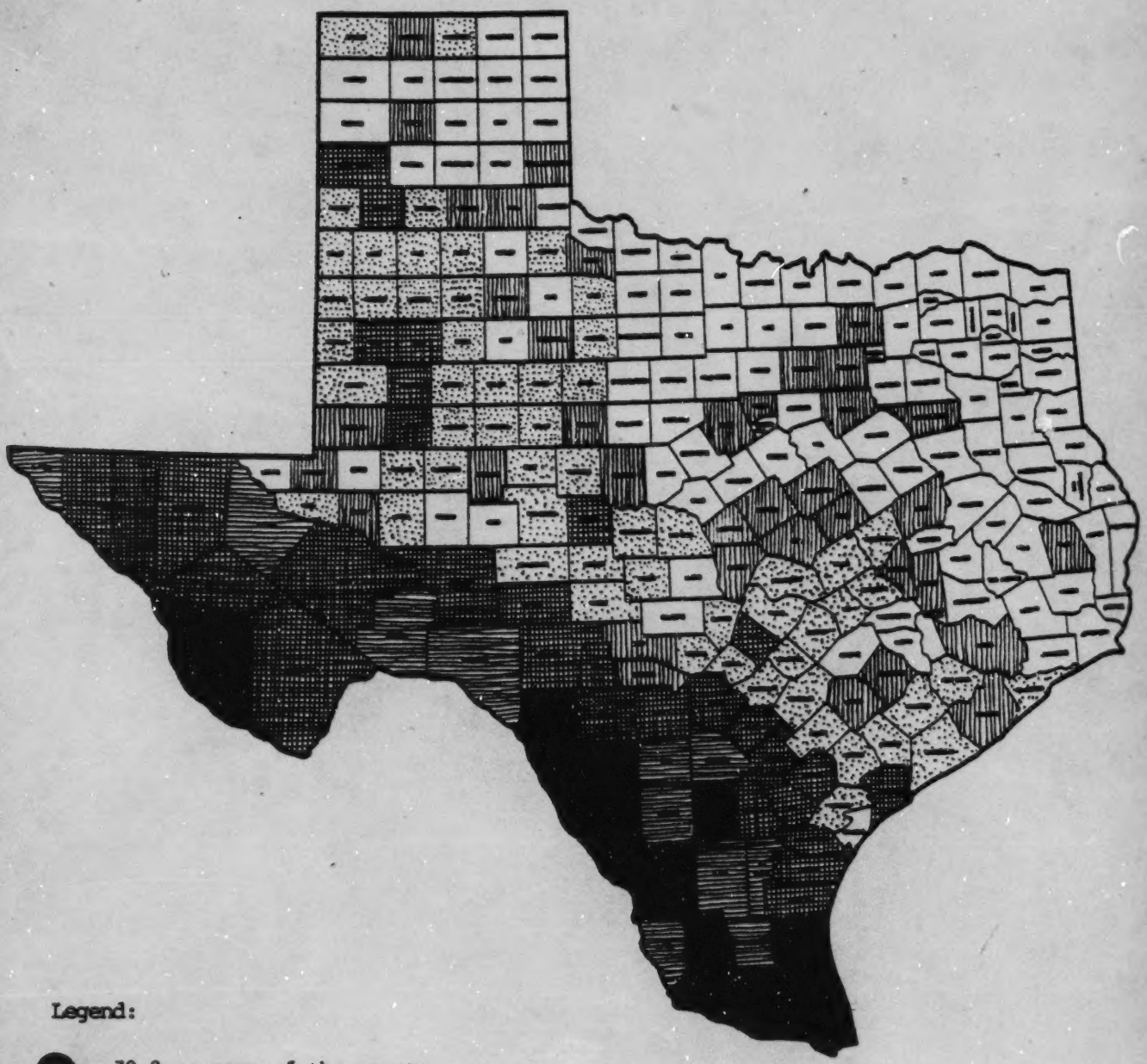
Map 4: The Spanish Language/Spanish Surname Population as a Percentage of the total County Population, by County, 1970.



Legend:

- 70.0 or more of the county
- 50.0 to 69.9%
- 30.0 to 49.9%
- 10.0 to 29.9%
- 5.0 to 9.9%
- less than 5.0%

Source: U.S. Census Bureau

were to draw an imaginary line from Port Lavaca to the southeastern corner of New Mexico, at Winkler County, the overwhelming majority of the Mexican American population would lie to the southwestern part of the line. The most notable exceptions are Martin, Dawson, Lynn and Terry Counties just south of Lubbock, and Castro and Deaf Smith Counties just southwest of Amarillo. However, considering the scarcity of the population in all six of these latter counties (see Map 2), it can be concluded that the overwhelming majority of the state's Mexican American population is at the southwestern end.

A comparison between Map 2 and Map 4 indicates that the SL/SS population does not comprise the majority of the state's overall population. On the contrary, the SL/SS and the rest of the majority of the state's population are clustered at opposite ends of the state from each other. There are some places where the heavier clusters of the population in general and the clusters of the SL/SS population are in the same place, notably Bexar, Nueces, Cameron and Hidalgo Counties, and in the Houston/Galveston area. However, on the map, the two populations seem at opposite ends.

Recall for a minute the fact that Cameron County is one of those fourteen counties that has over one percent of the state's population. Coupled with the fact that Cameron County is over 70% SL/SS, this leads one to speculate that a large number of SL/SS people in Cameron County are not receiving the same benefits that other comparable, yet predominantly Anglo, counties are receiving.

Again, there are many intervening variables that have to be explained, but based on our assumptions and research, our conclusions indicate that Cameron County is one of only two of the state's fourteen largest counties that is predominantly Mexican American and that this same county should have its own CMHC, yet it does not.

The CMHCs and the SL/SS Population. Map 5 demonstrates the locations of the CMHCs and the clustering of the SL/SS populations. Again, a curious situation arises. The CMHCs are clustered at the northeast part of the state and the SL/SS population hovers at the southwestern part. It almost appears that the CMHCs and the Mexican Americans are trying to avoid each other! However, it is more likely a matter of placing the CMHCs where the majority of the people live, rather than a deliberate avoidance tactic.

As far as adequate services to the SL/SS population, the only problematic area could be in the Rio Grande Valley area between Del Rio and Brownsville. While there are no dense population clusters in the area (as in the Population Arch along IH 35), there is still enough of a concentration of people in Val Verde, Webb, and especially Hidalgo and Cameron Counties to make one wonder why there are not more CMHCs there. Consider, for example, the Texarkana area, where the population is no more dense than Webb County's; they have a CMHC to serve a comparable area. Again, the Angelina County service area has less people than the Webb and Cameron areas; yet they have a CMHC there also. In fact, the areas of Brazos County, Grayson County, Harrison

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Map 5: The Community Mental Health Centers in Texas and the Spanish Language/Spanish Surname Population as a Percent of the County Population, 1970.

Legend:

- 70.0% or more
- 50.0 to 69.9%
- 30.0 to 49.9%
- 10.0 to 29.9%
- 5.0 to 9.9%
- Less than 5.0%

Source: U.S. Census Bureau

County, Brown County, Tom Green County, Hale County and Midland County all have as much as, or less than, a population than do the Webb to Cameron County areas; yet all of these areas have CMHCs while Webb and Cameron do not.

This is not in reference to the SL/SS population only, but to the total population. The main difference is that in the Webb to Cameron County area, the population is predominantly SL/SS while the above mentioned area has no more people and in some places even less people than Webb county. Certainly a further investigation is required to determine what effect the other variables have.

Major Highways. Besides the locations of the respective entities, another factor to consider in accessibility of mental health services to the SL/SS persons is the ease with which the clientele can get to the centers. Considering the information described supra, it becomes imperative that we consider the routes people must follow to get to the CMHCs, since the CMHCs are not often close by.

In considering accessibility to the CMHCs throughout the state, the author has defined major highways as either the interstates or the four-lane highways. While often a two-lane highway can be just as quick and convenient as a four-lane, there are many times when this is not the case; especially when one's psychiatrically impaired relative or loved one is in desperate need of services. In other words, since there is evidence to suggest that the CMHCs and the SL/SS population are not in the

same general areas, one can next inquire how easy is it for the consumer to reach the service providers. Anyone who has had a need to get somewhere quickly in an emergency knows that a four-lane road is preferable to a two-lane. For these reasons, only major highways are considered in the accessibility descriptions of the state.

Map 6 depicts the major highways of the state. The interstate highways criss-cross the state in a highly organized manner so that the outer regions have quick access to the central regions of the state and vice versa. While there is no interstate highway between Lubbock and points south, there are three major highways connecting these points so that it can readily be said that, once IH 37 between San Antonio and Corpus Christi is completed, the entire state will be efficiently connected by interstate highways.

The four-lane highways (non-interstate) are not as numerous. There is a lack of quick highways between the San Angelo, Brownwood, Abilene area and Austin. This is especially important since Austin is the state's capital. It is also surprising that there are no more major highways in the densely settled areas around Bryan and Lufkin. However, as indicated in Map 6, there is some access to the interstates.

There is also the unusual phenomenon of a major highway "in the middle of nowhere" to be seen in Map 6. Note for instance the fact that a four-lane highway connects Victoria to somewhere near Ganado in Jackson County, El Campo to Wharton in Wharton County,

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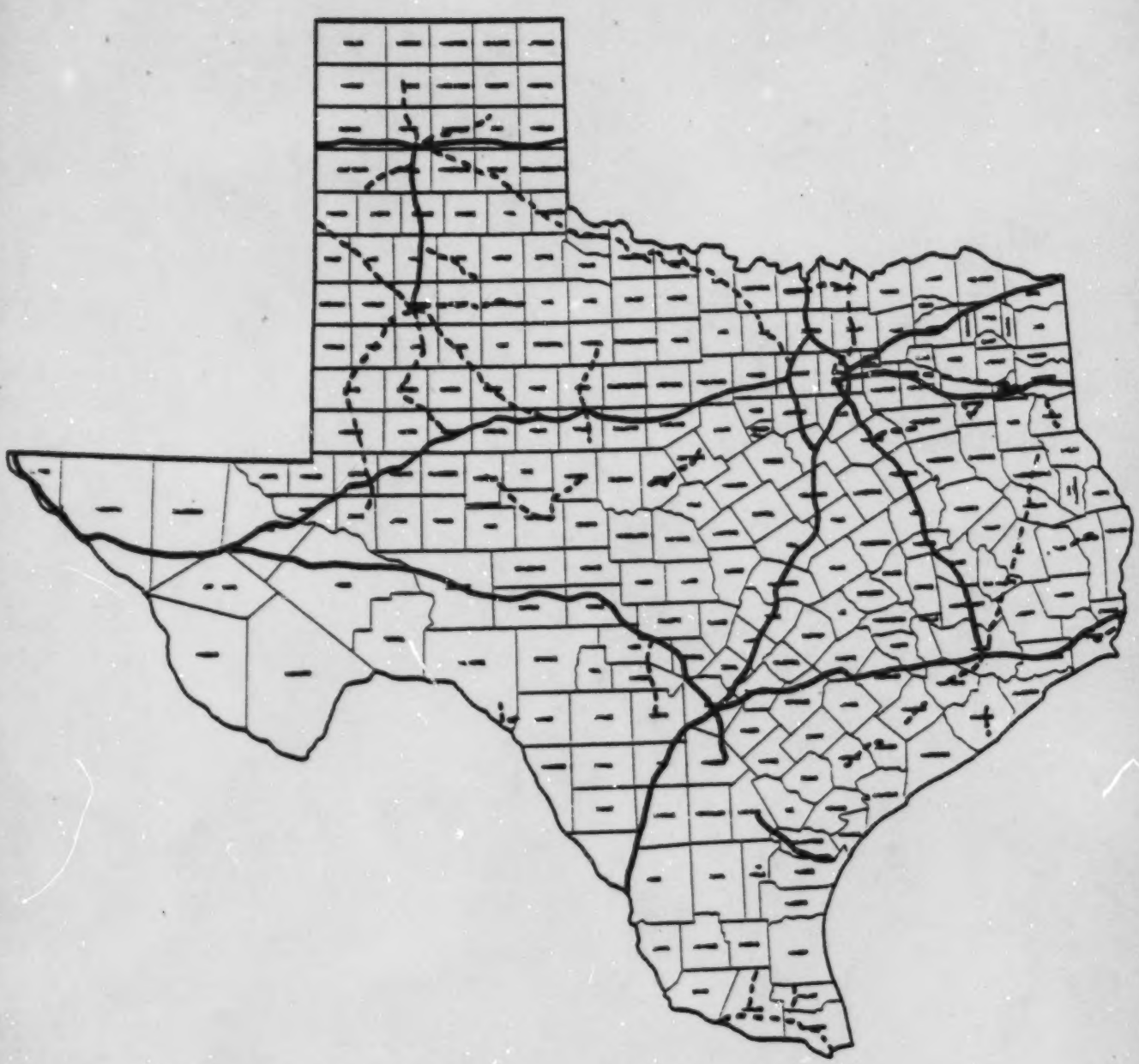
Map 6: The Major Highways of the State of Texas, 1978.



Interstate

Four Lane

Source: Texaco Road Map

Jasper to the Science Hall in Jasper County, Carthage and somewhere south of Marshall in Panola County, and Hondo to Kerrville. There is, no doubt, an explanation for each of these curious phenomena, but they do rather jump out on a state map!

The CMHCs and the Major Highways. Map 7 plots the CMHCs in relation to the major highways. There are only a few CMHCs that do not have a major highway connecting them and their service area. The Pecan Valley CMHC in Stephenville and the Brazos Valley Mental Health Center in Bryan have no major highways between them and their service areas. The Gulf Bend CMHC in Victoria and the Gulf Coast Center in Galveston have some major highway traffic in their service area, but part of their clientele could have problems getting to the CMHC. In other cases, there is an excellent connection between the centers and the service areas as in San Angelo, Brownwood, Lufkin, Edinburg and Dennison. All in all, it can be said that the CMHCs are predominantly located on a major highway.

The CMHCs, the General Population, and the Major Highways. The locating of the CMHCs on major highways becomes even more meaningful when considered alongside of the population centers of the state. Map 8 shows that the CMHCs, the major highways, and the population clusters are all in the same general area. The CMHCs have been placed in strategic locations throughout the state so that the clusters of populations can reach them on the major highways if coming from a distance, or else the CMHC is located in the same city as the centers of populations. While one

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Map 7: The Community Mental Health Centers in Texas and the Major Highways of the State, 1978.

Interstate

Four Lane

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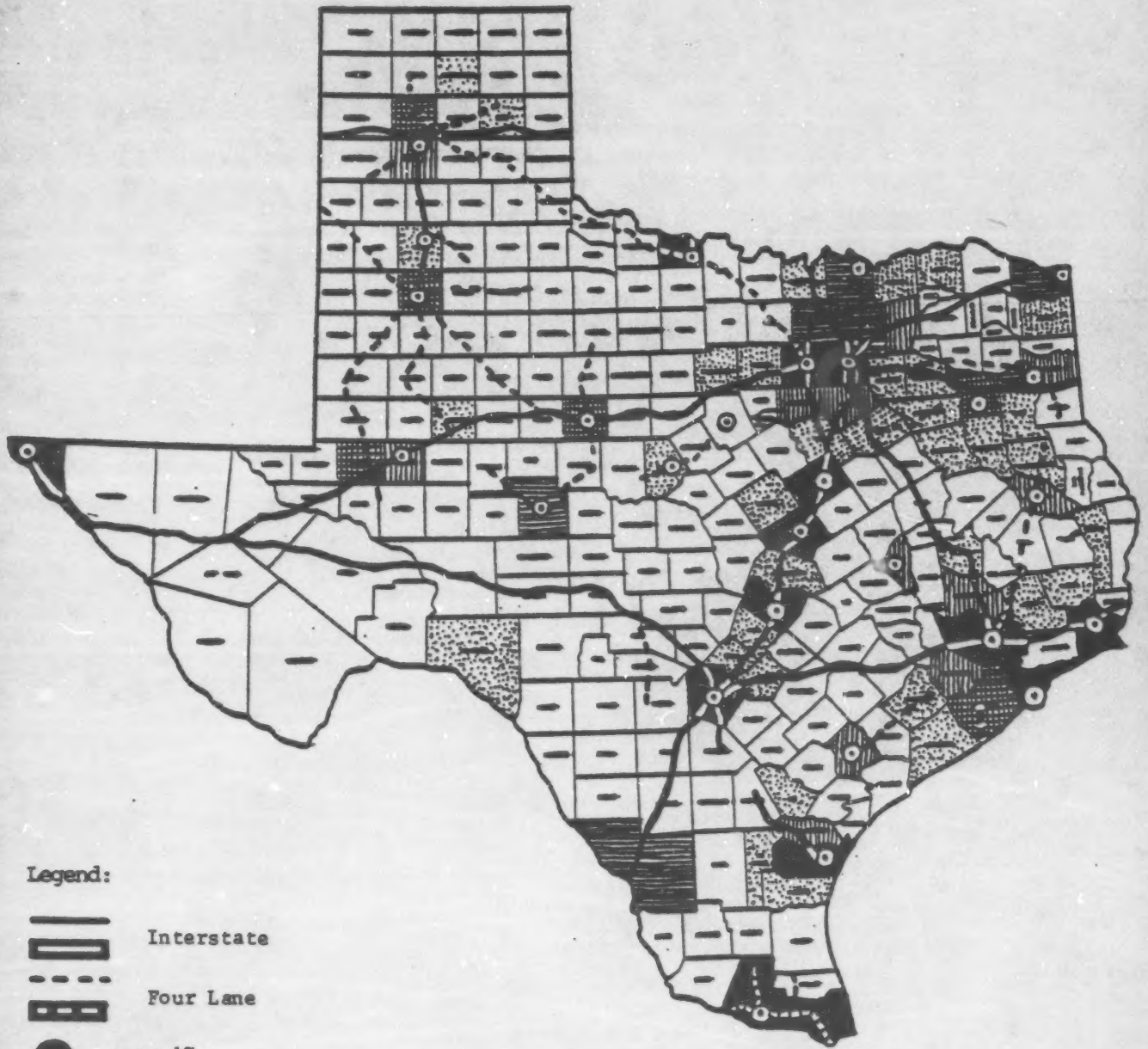
Map 8: The Community Mental Health Centers in Texas, the General Population as a percent of the Total State Population, and the Major Highways of the State, 1970.



Legend:

Interstate

Four Lane

over 1%

.8 to .99%

.6 to .79%

.4 to .59%

.2 to .39%

.0 to .19%

Source: U.S. Census Bureau
Texaco Road Map

could argue that major highways are not planned with CMHCs in mind, the converse should ideally be the case.

The CMHCs, the SL/SS Population, and the Major Highways. Map 9 presents a slightly different picture from Map 8. This map shows the CMHCs, the major highways, and the SL/SS population clusters rather than the general population clusters. As has already been pointed out, the majority of the SL/SS populations have no local, community-controlled CMHCs but state outreach centers instead. Should it become imperative or preferable to use the services of a CMHC rather than the outreach centers, the majority of the SL/SS population would not have a major highway between them and the center.

There is a four-lane highway between Brownsville and La Joya, with connections through Edinburg to the northern region of Hidalgo County. The lower Rio Grande Valley, therefore, has access to the center in Edinburg (this does not address the issue of acceptability of services as mentioned previously). However, the remainder of the predominantly SL/SS counties in southwestern Texas have few major highways; specifically the interstate between Hondo and San Antonio and portions of an interstate between San Antonio and Corpus Christi.

From this map, preliminary evidence can be presented to substantiate the theorum that CMHCs are not accessible to the SL/SS population in the state of Texas. Granted that the general population of the state clusters in the northeastern section and the CMHCs offer ready and accessible services to the majority of the

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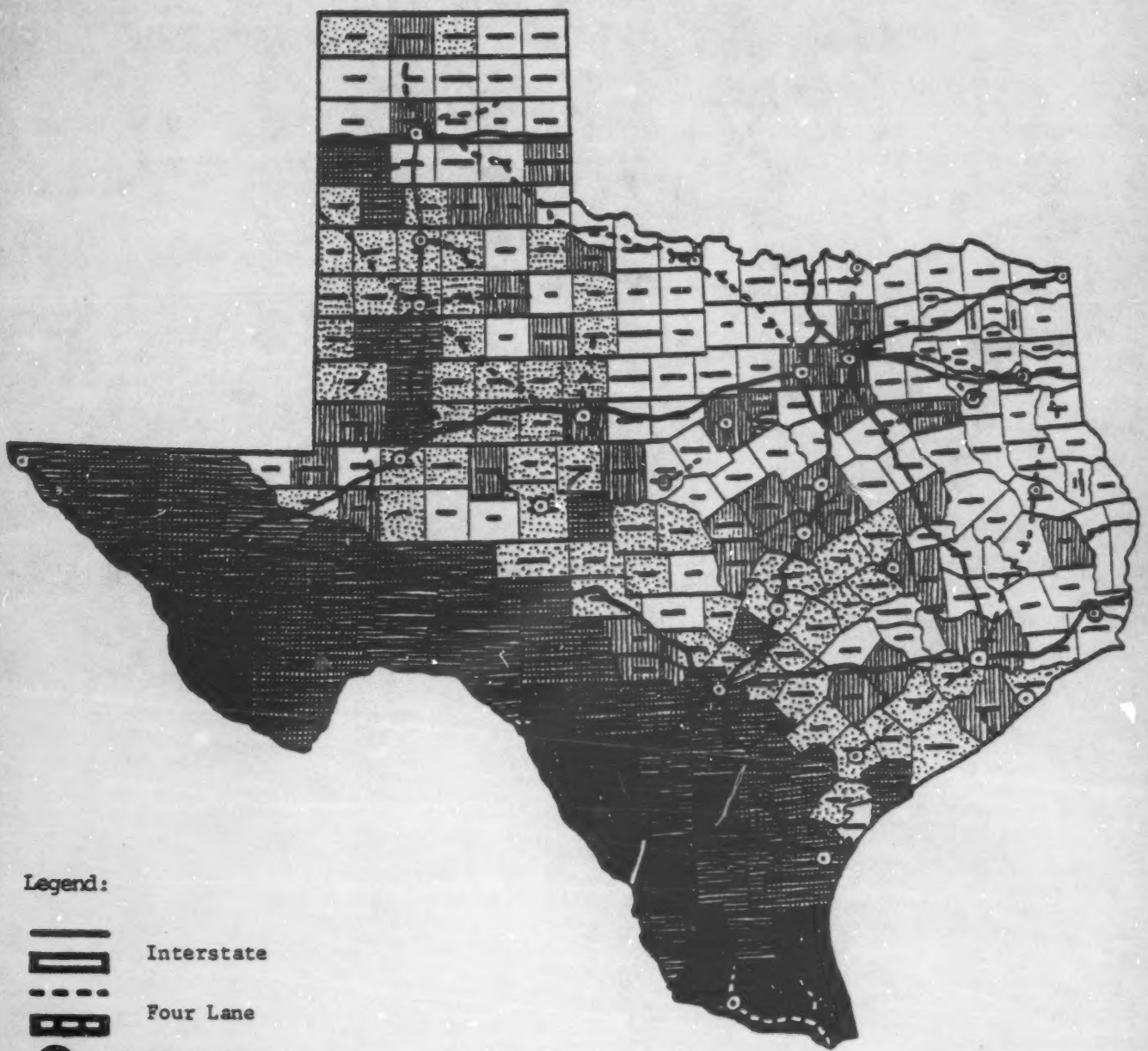
Map 9: The Community Mental Health Centers in Texas, the Spanish Language/Spanish Surname Population as a Percent of the Total County Population, and the Major Highways, 1970.



Legend:

- Interstate
- Four Lane
- 70.0% or More
- 50.0 to 69.9%
- 30.0 to 49.9%
- 10.0 to 29.9%
- 5.0 to 9.9%
- Less than 5.0%

Source: U.S. Census Bureau
Texaco Road Map

populations, it is not the majority of the general population that this study investigates, but rather the majority of the underprivileged minorities whom the law is intended to serve and to whom CMHC services could be more necessary due to the higher incidence of poverty and subsequent stress the underprivileged experience. The majority of this underprivileged minority does not have accessible CMHC services.

It cannot be overstressed that there may be innumerable unaccounted factors to each of the investigations and that these descriptions can offer no more than prima facie evidence upon which further and more exhaustive research can build. For the present, based on the evidence at hand, it can be concluded that the SL/SS population is being underserved.

Research Question #1, therefore, must be answered in the negative. The CMHCs throughout the state are not accessible to the SL/SS population clusters. They are, of course, more accessible to the majority of the SL/SS persons within their own catchment area, but the issue of availability of services to the majority of this population far outweighs the fact that services are accessible to those who reside within the center's catchment area. In other words, those SL/SS people that have CMHC services available to them can get there using a major highway, but the overwhelming majority of them do not have adequate access services to the available.

## Descriptive Comparisons

While this is a study of accessibility, the previous findings led the author to do some descriptive comparisons between portions of the state. These comparisons, while related to availability of services, are still concerned with the ease with which SL/SS persons in need of CMHC services can get to them. The fact that CMHC services are so far away from SL/SS people may make this study pertinent to availability issues as well.

Texas State Health Service Areas. The state of Texas is divided into twelve Health Service Areas. The Department of Health, Education and Welfare, along with the Texas state government, has made these divisions so as to better meet the health needs of Texas residents, focusing on the needs of specific areas in health planning and in organizing health systems. Map 10 portrays the twelve Health Service Areas (hereinafter HSAs). Eleven of the twelve have names descriptive of the area they envelope, so they will be called by their descriptive names. The Dallas and Fort Worth area has not been identified by a name other than Texas Area 5. For the purposes of continuity and ease of reference, Texas Area 5 will be called the Dallas/Fort Worth HSA in this report. In the HSA as well as in other divisions of the state, one notes the curious phenomenon, unexplainable by this author, of excluding Childress County from the Panhandle region. No doubt there is a valid explanation, but paper and pencil investigations cannot help but notice this curious appendage of the Tri-Region poking into the Panhandle.

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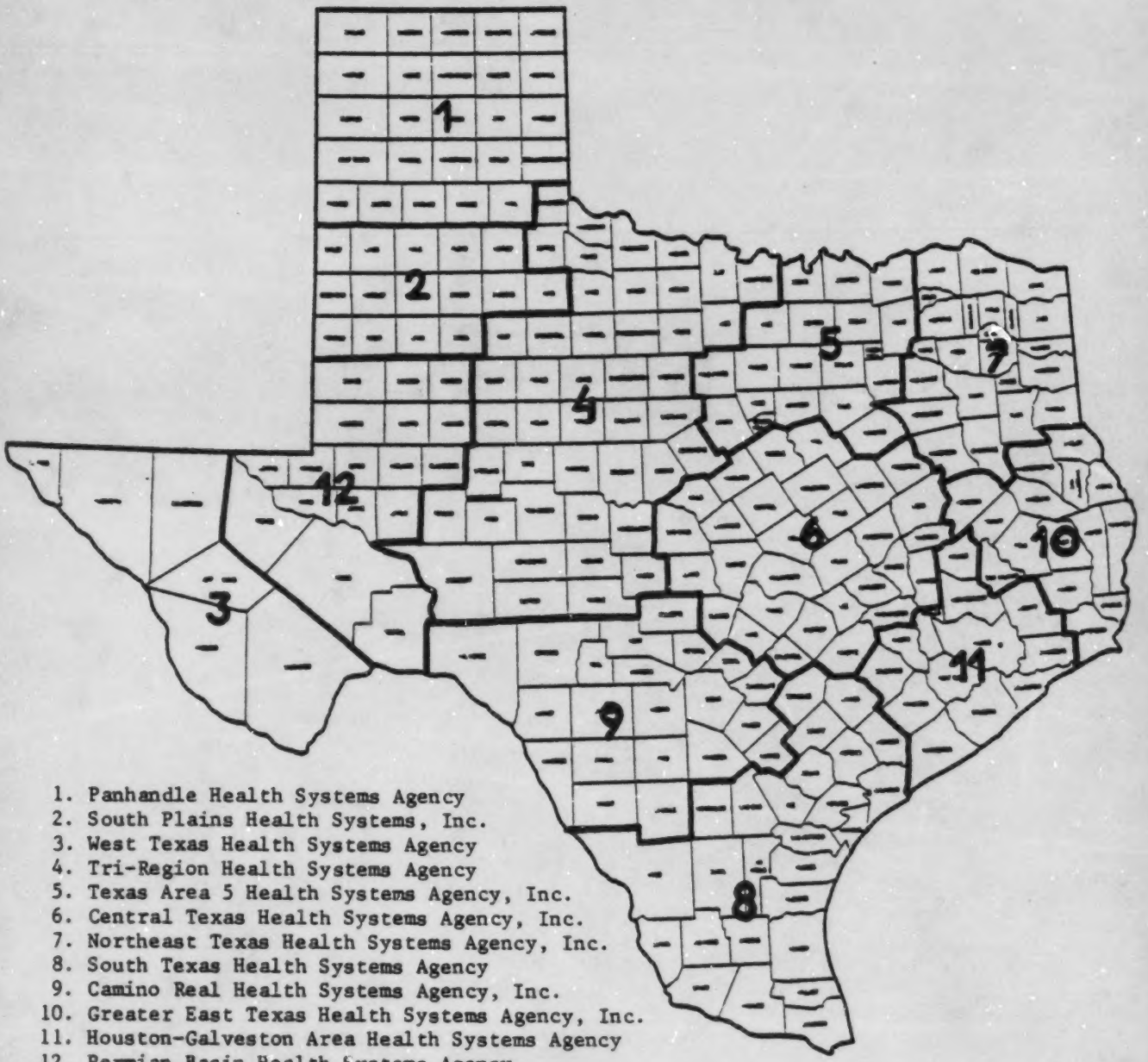
Map 10: The Texas State Health Service Areas, 1978.




1. Panhandle Health Systems Agency
2. South Plains Health Systems, Inc.
3. West Texas Health Systems Agency
4. Tri-Region Health Systems Agency
5. Texas Area 5 Health Systems Agency, Inc.
6. Central Texas Health Systems Agency, Inc.
7. Northeast Texas Health Systems Agency, Inc.
8. South Texas Health Systems Agency
9. Camino Real Health Systems Agency, Inc.
10. Greater East Texas Health Systems Agency, Inc.
11. Houston-Galveston Area Health Systems Agency
12. Permian Basin Health Systems Agency

Source: TDMHMR 1979 Annual Report

Population Distribution by HSA. Map 11 has the distribution of the general populations throughout the state. The most densely populated HSAs are Houston/Galveston and Dallas/Fort Worth. The South Plains and the Permian Basin are the least populated regions. The second most populated HSAs are Central Texas, Camino Real, and South Texas. When considered in HSAs rather than separate counties, the population density of the state, while still in the eastern section, is more evenly distributed through the central and southern portion of the state. In this instance, it is more appropriate to draw an imaginary line from somewhere near Orange, through Austin and west to the border of Val Verde County. This way we find about half of the state's population to the south of the imaginary line, with one cluster in the Dallas/Fort Worth HSA. However, it is still significant that nearly 45% of the state's population is in the Houston/Galveston and Dallas/Fort Worth HSAs.

The CMHCs and the HSA Regions. As shown in Map 12, the CMHCs have been rather carefully distributed, when considered by HSAs. While it may appear disproportionate that the Dallas/Fort Worth HSA has four CMHCs while Houston/Galveston has only two, it is not so when one considers that most of the people in HSA 11 live in Houston or in Galveston, wherein the two centers are located, and the other counties in the area are not as densely settled. What does seem unexplainable to the author is the fact that HSAs 4, 7 and 10 each have less people than Areas 6, 8 and 9 individually, yet the CMHCs seem better distributed in the former. In other words, Camino Real, Central Texas and South

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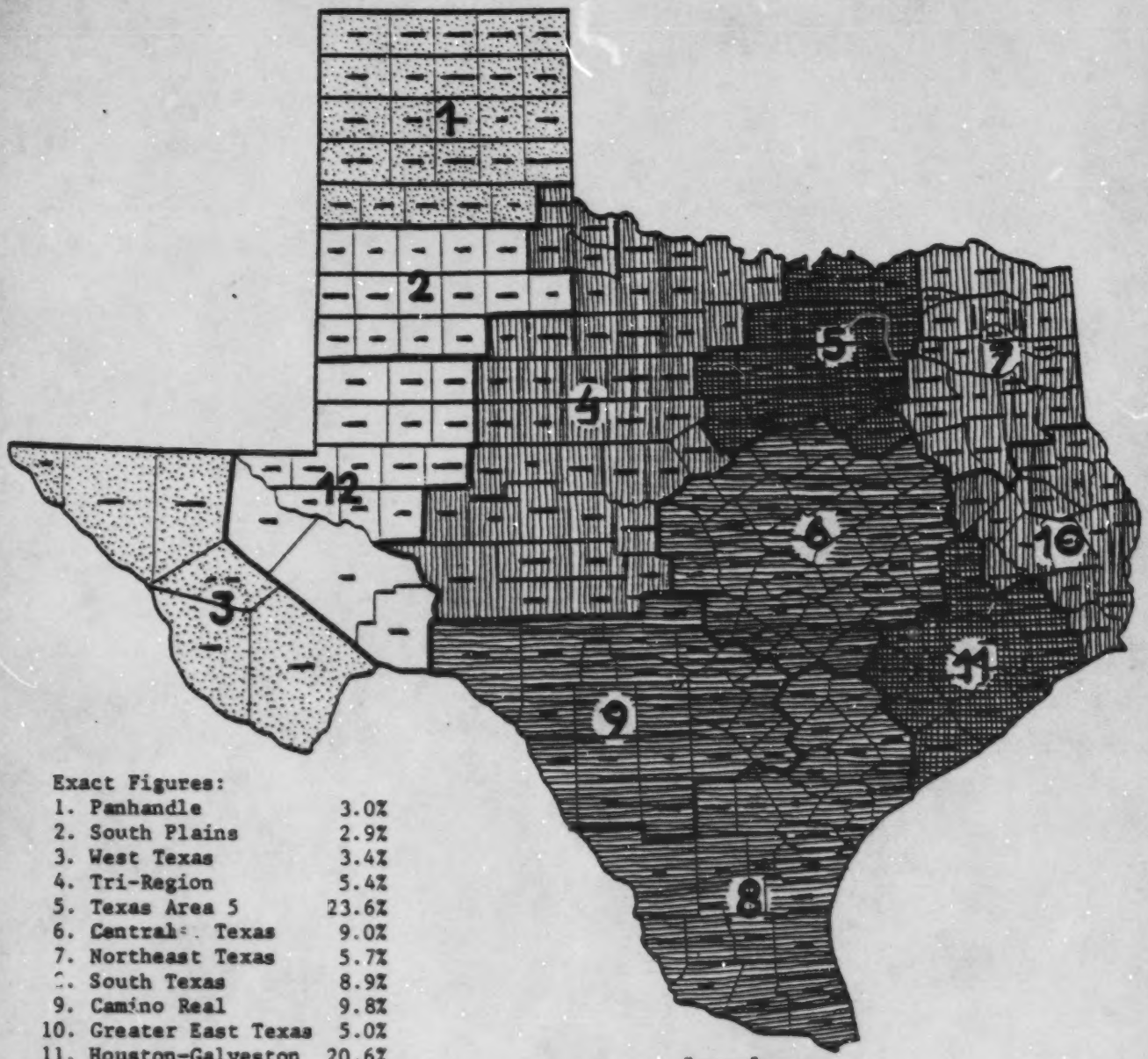
Map 11: The Distribution of the State's General Population, by Health Service Areas, 1970.




Exact Figures:

| | |
|---|---|
| 1. Panhandle | 3.0% |
| 2. South Plains | 2.9% |
| 3. West Texas | 3.4% |
| 4. Tri-Region | 5.4% |
| 5. Texas Area 5 | 23.6% |
| 6. Central Texas | 9.0% |
| 7. Northeast Texas | 5.7% |
| 8. South Texas | 8.9% |
| 9. Camino Real | 9.8% |
| 10. Greater East Texas | 5.0% |
| 11. Houston-Galveston | 20.6% |
| 12. Permian Basin | 2.7% |

Legend:

- over 20%
- 8.9 to 9.8%
- 5.0 to 5.7%
- 3.0 to 3.4%
- less than 3.0%

Source: 1970 Census

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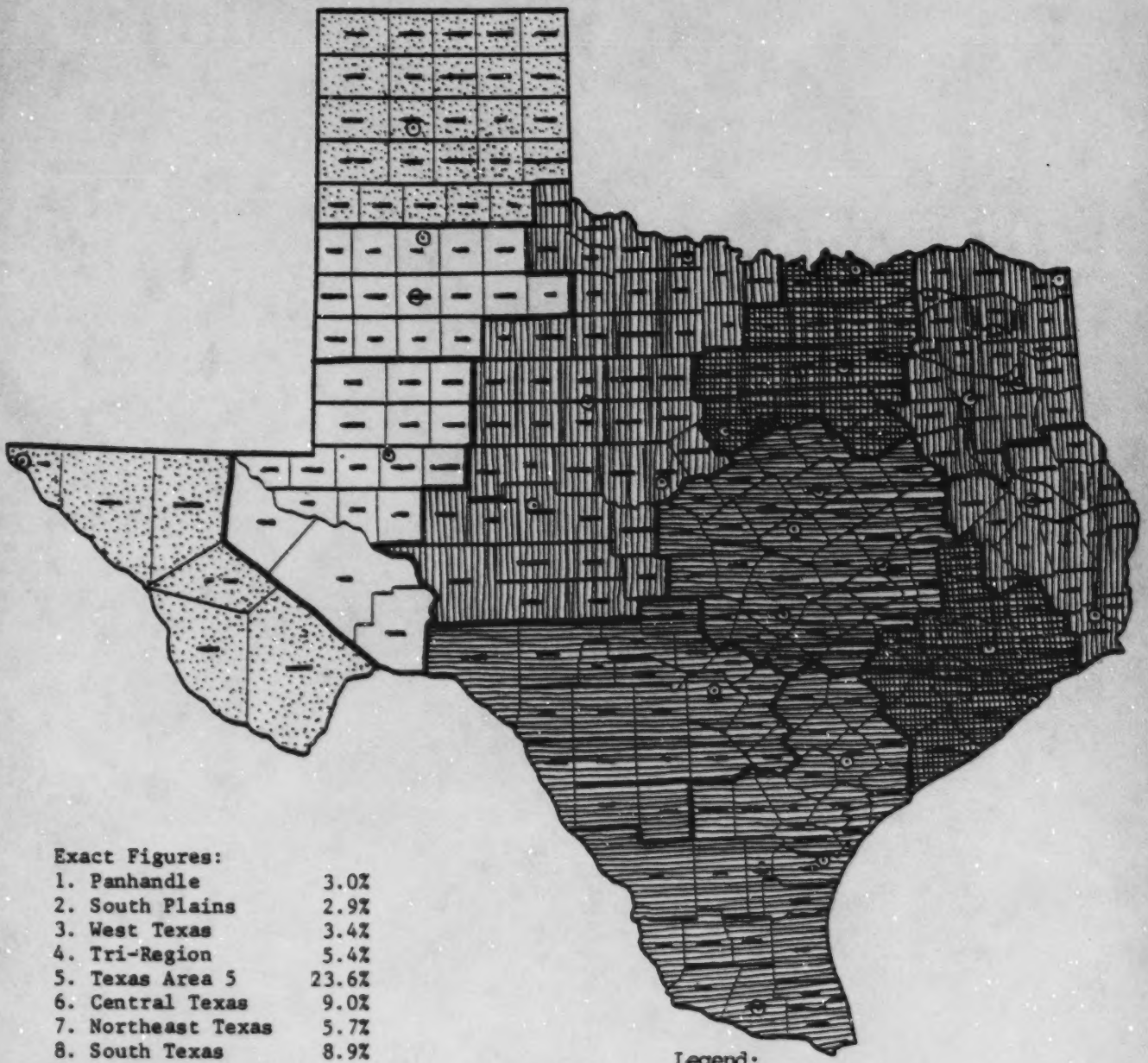
Map 12: The Community Mental Health Centers in Texas
and the General Population Distribution, by Health Service Area, 1970.



Exact Figures:

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| 7. Northeast Texas | 5.7% |
| 8. South Texas | 8.9% |
| 9. Camino Real | 9.8% |
| 10. Greater East Texas | 5.0% |
| 11. Houston-Galveston | 20.6% |
| 12. Permian Basin | 2.7% |

Legend:

- over 20%
- 8.9 to 9.8%
- 5.0 to 5.7%
- 3.0 to 3.4%
- less than 3%

Source: 1970 Census

Texas have more people than Tri-Regions, Northeast Texas and Greater East Texas, yet the latter have one more CMHC than the former: in effect, more centers serving less people!

The comparison becomes even more curious when one considers that the Central Texas HSA has 9.0% of the state's population and Tri-Region has 5.4% of the state's population yet they each have four CMHCs. The South Texas HSA has 8.9% of the state's population while Northeast Texas has 5.7% and, again, they share equal numbers of CMHCs! Finally, Area 9, Camino Real, has more people than either Areas 4, 7 or 10, and almost as many as any <u>two</u> of these combined, yet claims only <u>one</u> CMHC. Tri-Region has four CMHCs to serve less people! The Northeast Texas and Greater Eastern Texas HSAs have four CMHCs to serve 10.7% of the state's population, while Camino Real has one CMHC to serve nearly the same percentage (9.8%). It seems that the CMHCs in general tend to cluster in the northeast section of the state, and they seem to favor the Tri-Region Area. For some reason the southwestern portion of the state continues to be underserved, even when divided by HSAs.

The Health Service Areas can be considered from yet another angle. The SL/SS populations, we know already, are centered in the southwestern portions of the state. It is probably a mere coincidence that the state underserved the areas that are predominantly SL/SS, but this investigation indicated the possibility of a pattern. Consider the following information as evidence.

The HSA Regions and the SL/SS Populations. There are three HSAs that are predominantly SL/SS as shown on Map 13. These are Camino Real (45.4% of the area's population), West Texas (56.9% of the area's population) and South Texas (58.5%). There are three other areas that have large numbers of SL/SS persons: South Plains with 20.1% of its population, the Permian Basin with 18.8%, and Central Texas with 11.3%. Those areas noticeably lacking in SL/SS representation among their respective populaces are Dallas/Fort Worth, Northwest Texas, and Greater East Texas; again, at opposite ends of the state from those predominantly SL/SS areas.

It should be pointed out that the West Texas HSA has very few residents. Only in El Paso County is there any clustering of the population, and the CMHC is located in El Paso. Therefore, El Paso shall not be included in this section of the descriptive comparisons due to the scarcity and poor distribution of the population. South Texas and Camino Real shall represent the predominantly SL/SS areas in this descriptive comparison.

The CMHCs and the HSA Regions. There are a total of four CMHCs in the Camino Real and South Texas Areas, one in the former and three in the latter. Map 14 plots the CMHCs throughout the state by HSAs. There are a total of four HSAs in the state that have only one CMHC within their borders. These are West Texas, Panhandle, Permian Basin and Camino Real. Recalling Map 11, the Panhandle, West Texas and Permian Basin Areas have 3.0%, 3.4% and 2.7% of the state's population, respectively. However, Camino

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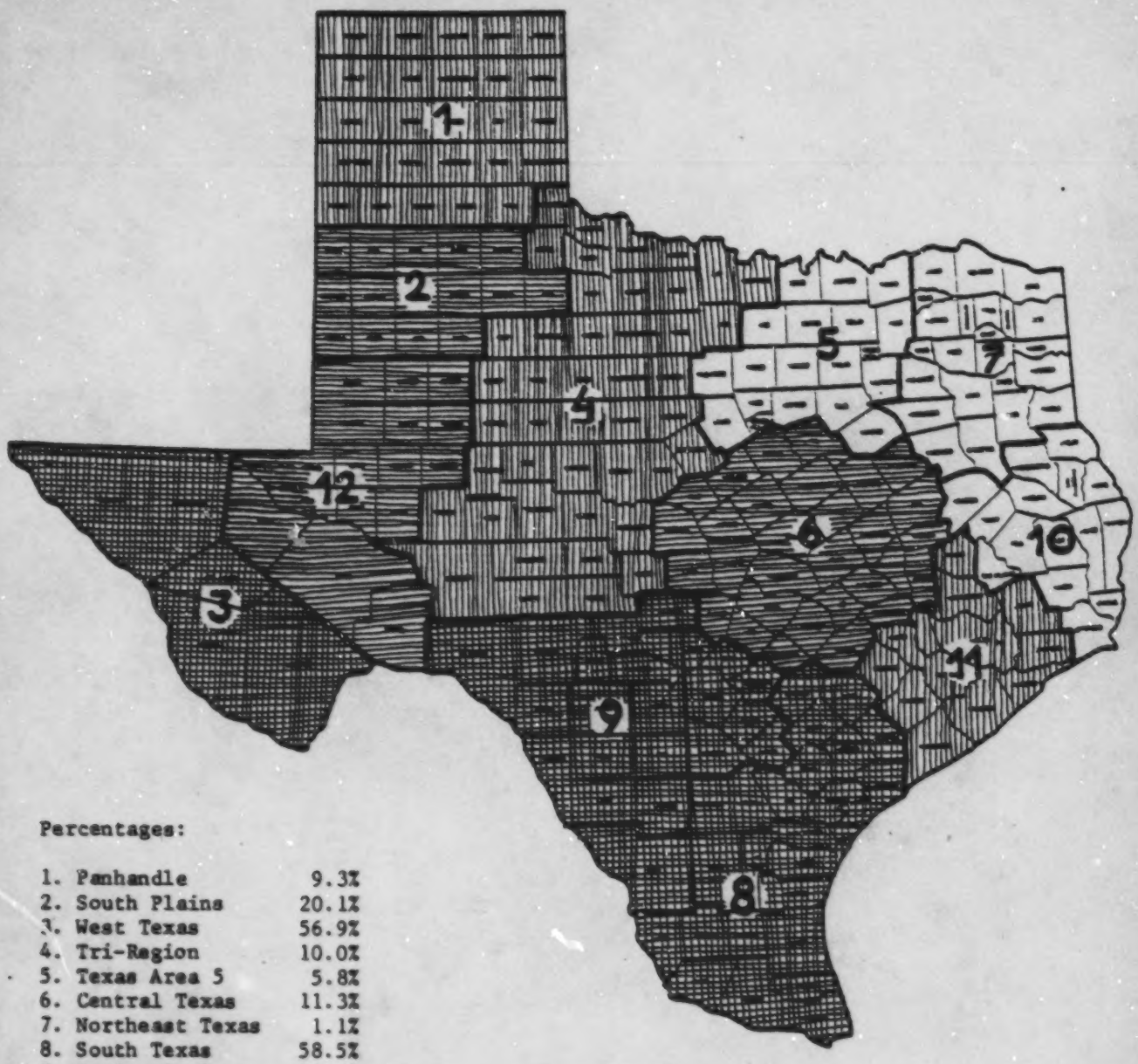
Map 13: The Percent of the Health Service Area Population that is Spanish Language/Spanish Surname, by Health Service Area, 1970.




Percentages:

| | |
|---|---|
| 1. Panhandle | 9.3% |
| 2. South Plains | 20.1% |
| 3. West Texas | 56.9% |
| 4. Tri-Region | 10.0% |
| 5. Texas Area 5 | 5.8% |
| 6. Central Texas | 11.3% |
| 7. Northeast Texas | 1.1% |
| 8. South Texas | 58.5% |
| 9. Camino Real | 45.4% |
| 10. Greater East Texas | 3.1% |
| 11. Houston-Galveston | 10.8% |
| 12. Permian Basin | 18.8% |

Source: 1970 Census

Legend:

- 45.4 to 58.5%
- 11.3 to 20.1%
- 9.3 to 10.8%
- 1.1 to 5.8%

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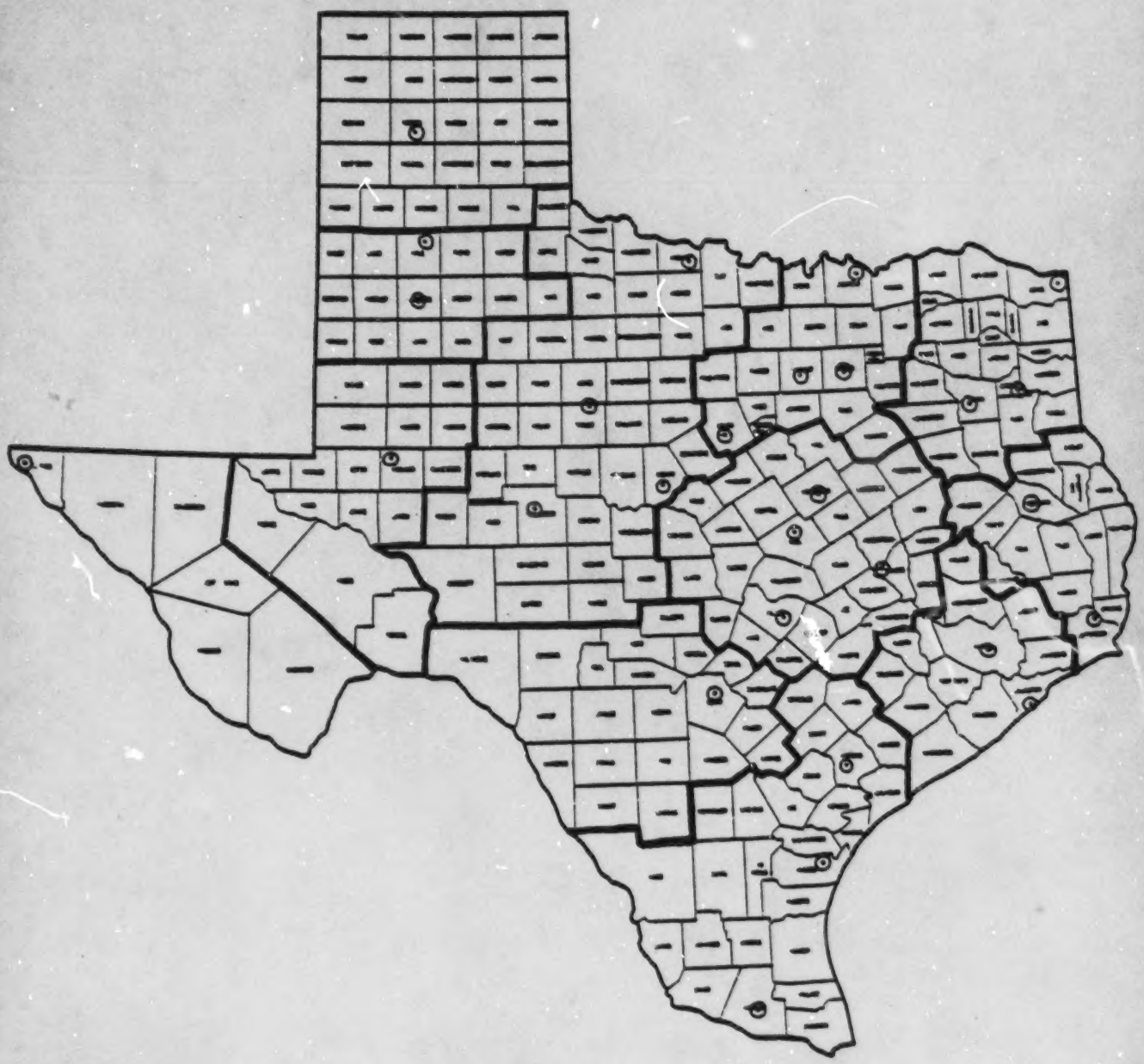
Map 14: The Community Mental Health Centers in Texas, as Distributed by Health Service Area, 1978.



Source: TDMHMR 1979 Annual Report

Real has more residents than all three combined and still has only one CMHC. The other two regions with comparable populations have three or four CMHCs, which is better, but still not as good as some other regions.

The CMHCs, the HSA regions, and the SL/SS Population. Map 15 represents the SL/SS distribution and the CMHC locations. It becomes increasingly apparent that a pattern may exist. Comparisons of Camino Real and South Texas with Dallas/Fort Worth, Northeast Texas and Greater East Texas are indicated. Northeast Texas and Greater East Texas have very small SL/SS populations (1.1% and 3.1%, respectively) and Dallas/Ft. Worth, while having a slightly larger SL/SS population, is still extremely small (5.8% of the area population). Comparing these three to a larger area, that of Camino Real and South Texas, shows that the northeast corner has nine CMHCs while the southern edge has a full forty-four percent less (only 4 CMHCs). While a quick and ready defense of the present distribution of the CMHCs could be that there are more people in general (i.e., a heavier concentration of Texans without regard to national origin) in the northeast corner, this cannot be accepted as valid due to the following information.

Recalling Map 11 again, it is evident that South Texas and Camino Real have 8.9% and 9.8%, respectively, of the state's population, while Northeast Texas and Greater East Texas have 5.7% and 5.0% of the state's population, respectively. Comparing the latter two, which together have 10.7% of the state's popula-

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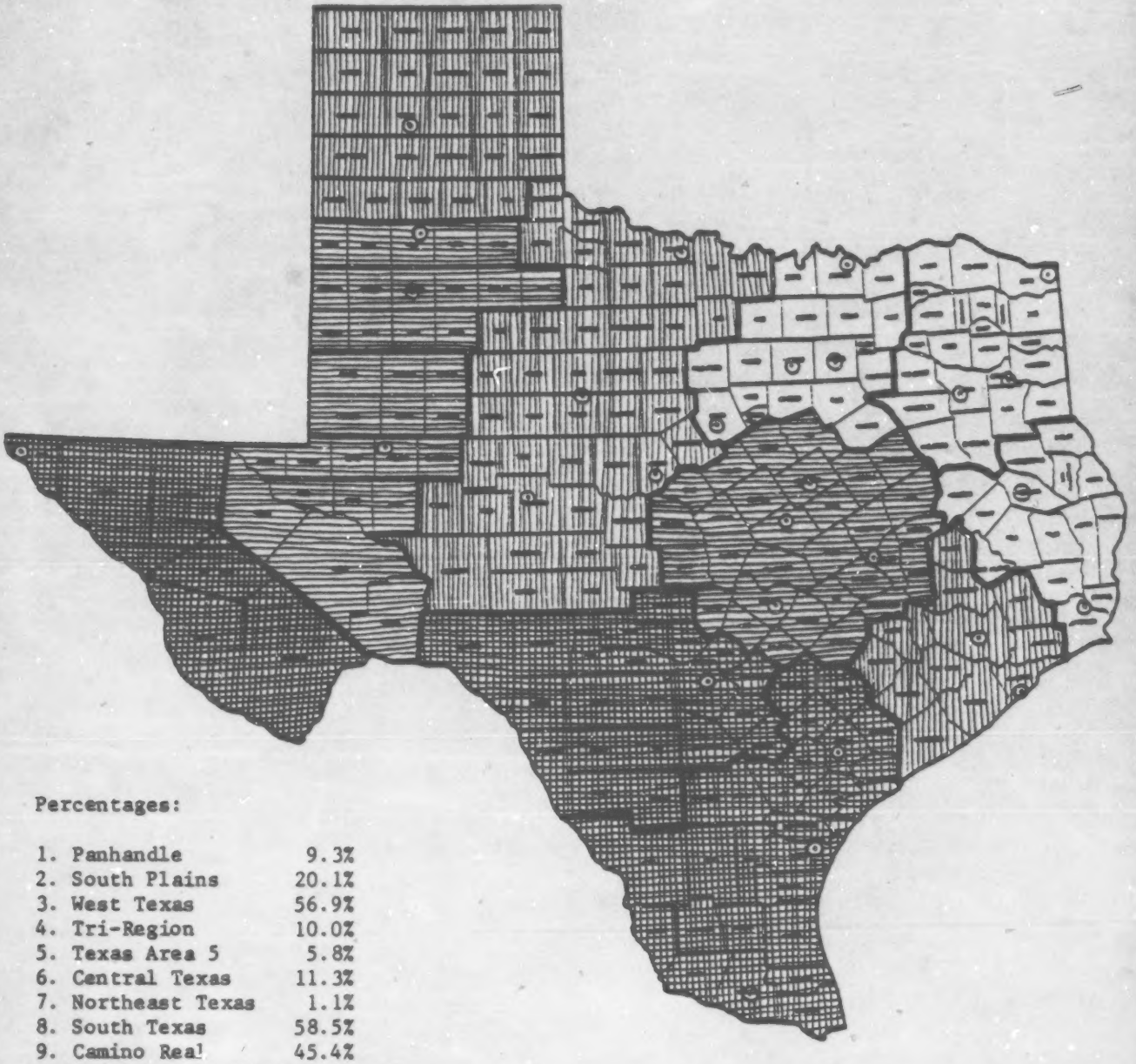
Map 15: The Community Mental Health Centers and the Spanish Language/ Spanish Surname Population as a Percentage of the Total Health Service Area Population, by Health Service Area, 1970.



Percentages:

| | | |
|---|---|---|
| 1. | Panhandle | 9.3% |
| 2. | South Plains | 20.1% |
| 3. | West Texas | 56.9% |
| 4. | Tri-Region | 10.0% |
| 5. | Texas Area 5 | 5.8% |
| 6. | Central Texas | 11.3% |
| 7. | Northeast Texas | 1.1% |
| 8. | South Texas | 58.5% |
| 9. | Camino Real | 45.4% |
| 10. | Greater East Texas | 3.1% |
| 11. | Houston-Galveston | 10.8% |
| 12. | Permian Basin | 18.8% |

Legend:

- 45.4 to 58.5%
- 11.3 to 20.1%
- 9.3 to 10.8%
- 1.1 to 5.8%

Source: 1970 Census

tion to the former two which have 17.7% of the state's population, one cannot help but wonder why the one, with a smaller region and smaller population, would have more centers than the other.

Once again, there are surely many data that this report has not taken into account, but the pattern surfaces time and again so consistently that it seems that a very sophisticated design and highly advanced research will be required to find some reason for the differences other than the fact that one region is predominantly Anglo and the other is predominantly SL/SS.

This pattern becomes even more apparent upon noting the location of the twenty-ninth center. This latest center could not be included in the descriptions because, as of the latest data dissemination from TDMHMR, full services had not been started at this center; only administrative and clerical duties had been initiated. This twenty-ninth center, despite the scarcity of centers in the southwestern areas of the state, has been established in HSA 5, the Dallas/Fort Worth area, between Sherman and Dallas, in McKinney. Thus, it seems that growth patterns could be towards the directions that have lower numbers of SL/SS men and women rather than the opposite. While one more CMHC in an already well-served area does not indicate discriminatory practices, it does lend itself to question and criticism.

## One Intervening Variable

One variable that should be accounted for is the distribution of psychiatrists throughout the state. While few indigent people would consider seeking a psychiatrist's help, the fact remains that there may be less of a need for a CMHC if there are a good number of psychiatrists in the area.

For this final statewide description, the state shall be divided into the Districts of the American Psychiatric Association (A.P.A.). Map 16 displays the 11 A.P.A. districts established throughout the state. This map also indicates the number of psychiatrists per A.P.A. district. This number ranges from 19 in the El Paso area to 239 in the Houston area as of June 1979. The Dallas/Fort Worth area and the San Antonio/ Laredo area have the second and third highest numbers of psychiatrists.

The distribution of the state's general population, as a percent of the overall population, by county, is represented in Map 17 which is also divided by A.P.A. district. All in all, the psychiatrists go where the people are; the more densely settled areas have the greater number of psychiatrists. The Population Arch in central Texas claims nearly all the psychiatrists, with the Houston area having nearly all the rest. Map 18 depicts the distribution of psychiatrists in the state and the SL/SS population. It seems that there is a more equitable distribution of psychiatrists among the SL/SS population. However, this may not be the case as, once again, there may be too many intervening elements.

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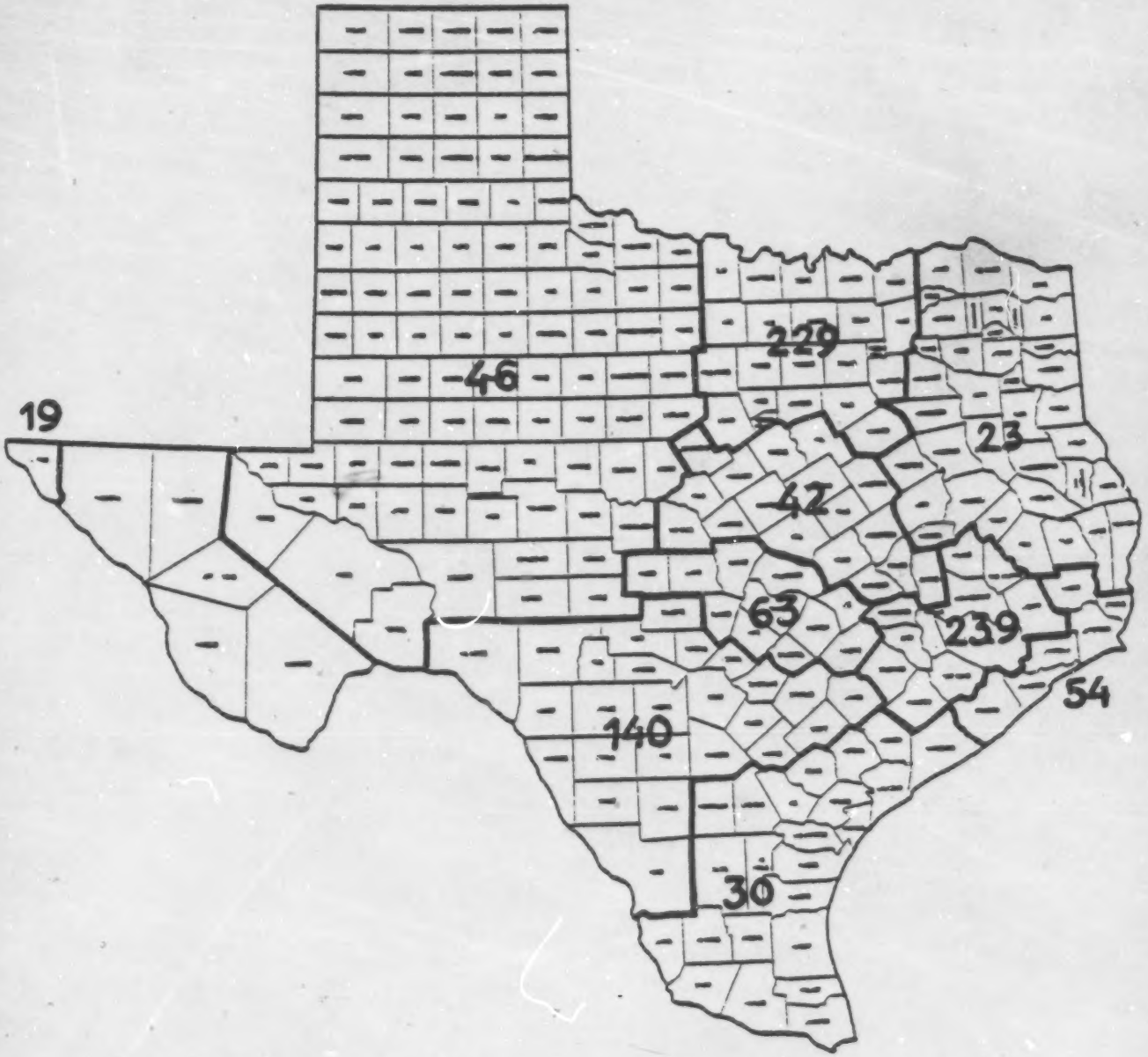
Map 16: Number of Psychiatrists who were members of the Texas District Branch, American Psychiatric Association, June, 1979, by American Psychiatric Association Districts




Source: American Psychiatric Association

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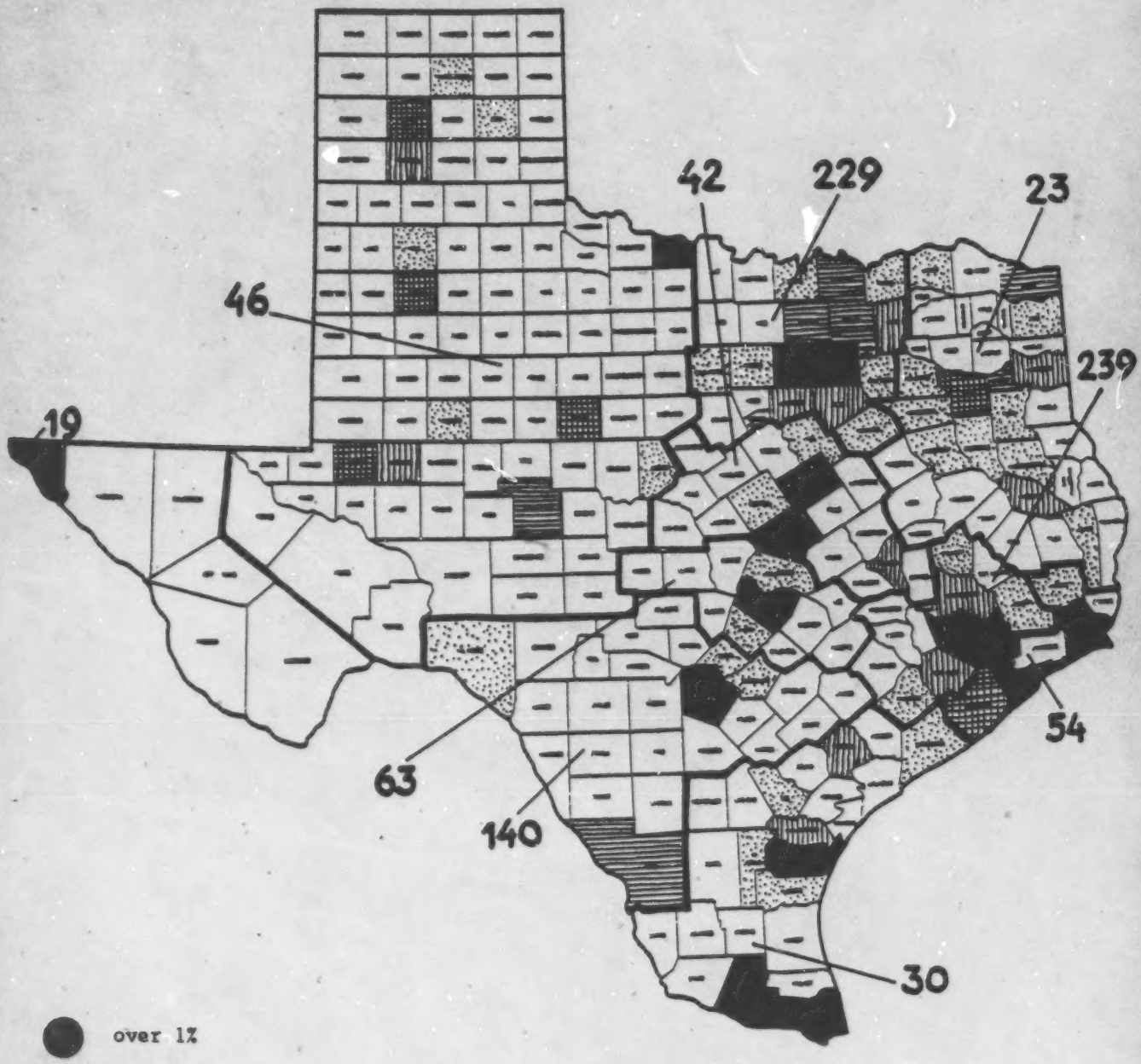
Map 17: The Number of Psychiatrists per American Psychiatric Association District and the Percent of the Total State Population, by County, 1979.




Source: American Psychiatric Association

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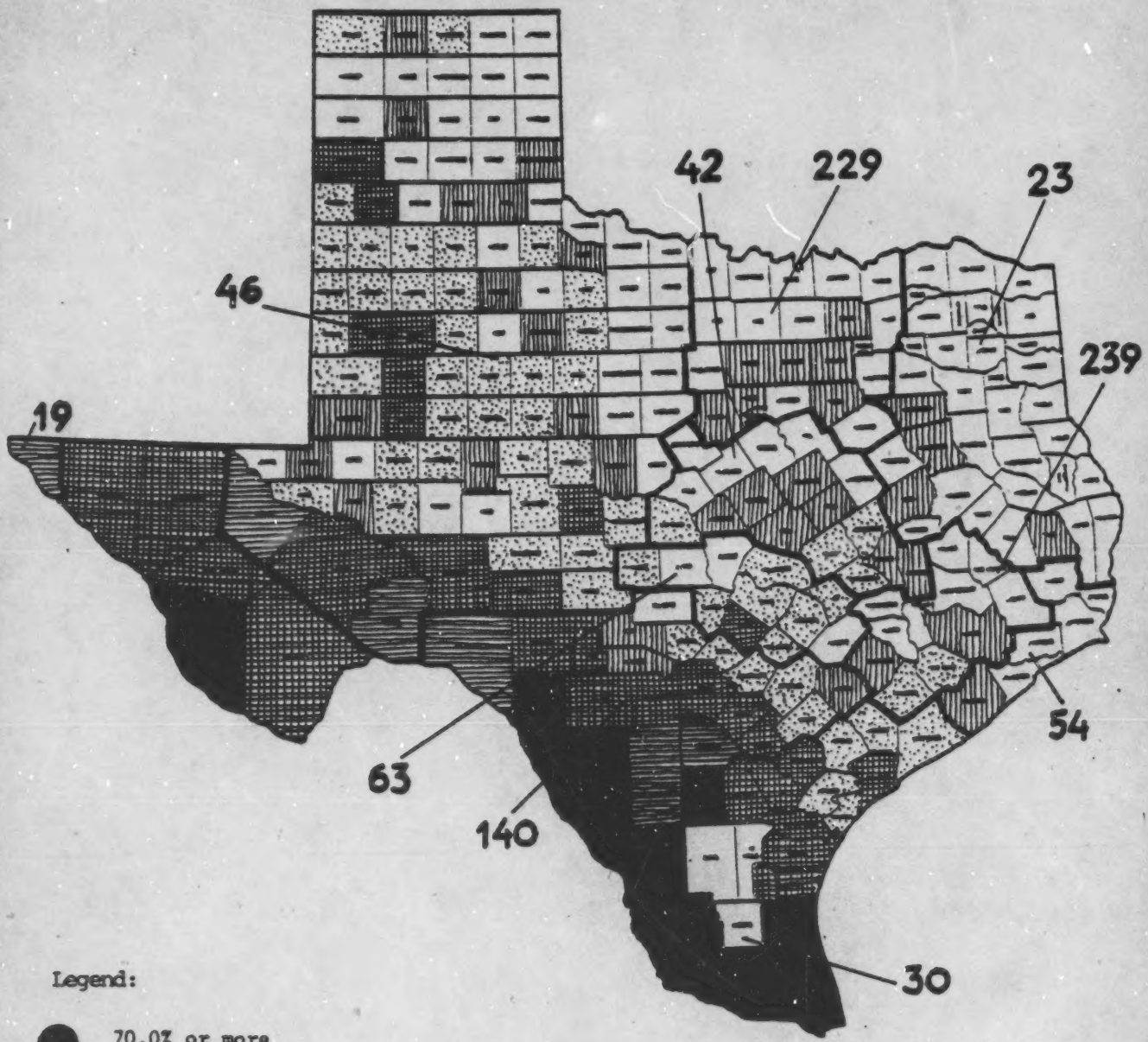
Map 18: The Number of Psychiatrists per American Psychiatric Association District and the Percent of the total County Spanish Language/ Spanish Surname Population, by County




Legend:

- 70.0% or more
- 50.0 to 69.9%
- 30.0 to 49.9%
- 10.0 to 29.9%
- 5.0 to 9.9%
- Less than 5.0%

Source: U.S. Census, 1970
American Psychiatric Association

Consider the case of the Bay City to Brownsville district against the Texarkana to Lufkin district. The former has 30 psychiatrists while the latter has 23. One would be tempted to say that there is more access to a psychiatrist in the southeastern than the northeastern region. However, if most psychiatrists are in Corpus Christi, then the rest of the region may not have any psychiatrists at all. The same can be said for Texarkana.

Consider also the fact that the Veteran's Administration Psychiatric Hospital is in Waco. This could mean that the majority of the psychiatrists in that district work in one place. Thus, it cannot be concluded assuredly that the distribution is equitable. But, again, on the basis of descriptive evidence, it must be said that psychiatrists are evenly distributed throughout the state.

Placed in juxtaposition to the fact that most of the SL/SS people in Texas are socioeconomically either lower or working class and that most lower or working class people usually would not go to psychiatrists due to financial reasons, the distribution of psychiatrists is rather insignificant to the SL/SS population.

Conclusion. Regarding the first Research Question, whether or not CMHC services are accessible to SL/SS folk within the same region the center is located, the answer is an overwhelming no. This is not to say that CMHC services are not accessible to all residents throughout the state, but only to the SL/SS residents. The regions of the state that are predominantly Anglo have more CMHCs in smaller regions than those regions that are predominantly SL/SS. The conclusion is based on the following observations.

With regard to the population distributions:

(1) The majority of the CMHCs and the majority of the SL/SS population are at opposite ends of the state from each other: the former in the northeastern region and fanning out into the central, and the latter clustering in the southeastern region and inching toward the central.

(2) Webb County and especially Cameron County do not have CMHC services comparable to what other counties of the same size, yet predominantly Anglo in population, have.

With regard to the major highways:

(1) Stephenville and Bryan are the only CMHCs without major highway connections. Both of these centers are located in counties that are 10% to 30% SL/SS, which in turn are in the Central Texas Area, which is 11.3% SL/SS. While it cannot be said that a large SL/SS population is receiving less services, it can be said that the population of Area 6 in general may have problems with accessibility.

2) The majority of the SL/SS people residing outside the major cities in the state have no major highway between them and a CMHC. There are some major highways between the SL/SS population and the services available at the CMHCs, but not enough to warrant easy utilization.

(3) The SL/SS residents are being underserved with regard to CMHC services, due to the poor accessibility to these centers.

With regard to the comparisons between HSAs: Areas 8 and 9, and possibly Area 6, are being underserved when compared to similar populations in other regions of the state.

All in all, it becomes apparent that the possibility of a pattern throughout the state exists. There is not yet enough evidence to come to an ironclad conclusion of a consistent underserving of the SL/SS Texans, but such evidence was not the goal of this research. It is the goal of this study to explore and describe; compare and wonder why. This approach suggests that one must hint in the direction of a pattern and call for continued research to determine the reality of this pattern and, if possible, its causes.

In conclusion, the author has brought about a preliminary description of the mental health services to the SL/SS people of Texas. Certain peculiar patterns tend to appear and several curious phenomena have been observed. This has led to posing several questions that beg answers before meaningful changes can be made in the services of the CMHCs to the SL/SS. A few explanations have been suggested as to why the present circumstances

exist. Undoubtedly, no single explanation in and of itself can answer the questions, but most likely the causes of the present situation are multiple. This, in turn, will make the solution more difficult. No doubt the research that this study may generate will lead us further in that direction.

## Chapter Two: The Five Major Cities

The five major cities to be described in this study are El Paso, Fort Worth, San Antonio, Dallas and Houston. There are other large metropolitan areas in the state, but these five are the largest. As previously mentioned, these five areas contain approximately 45% of the state's entire population so that the state has been, more or less, divided in half. The five cities will be described in ascending order by population.

For the purposes of this study, the five cities can be described more precisely as the five most densely populated catchment areas in the state. That is, the descriptions will not be of the city proper, or of the standard metropolitan statistical area (SMSA), but rather of the catchment area of the mental health center serving the community. For example, Dallas is the second largest city in the state. The city of Dallas will be included in this description, but this study will consist of a description of Dallas County rather than Dallas proper or of the Dallas SMSA (which extends beyond Dallas County). Thus, while the discussion will focus on "Dallas," it will include all of Dallas County. The El Paso CMHC catchment area covers El Paso County; Fort Worth's CMHC catchment area (called Trinity Valley) covers all of Tarrant County; San Antonio's covers all of Bexar County; and Houston's covers all of Harris County. Therefore, reference to the centers by the name of the city shall be as a convenience rather than a boundary.

El Paso. The fifth largest city in the state of Texas had 322,261 residents in 1970. The catchment area for the El Paso Center for Mental Health Services is the entire county. El Paso County had 359,291 residents in 1970. Of these, 204,349 or approximately 57% were SL/SS. Map 19 is a representation of El Paso County, with Map 20 being a representation in more detail of the city proper. Map 20 also includes a plotting of the CMHCs within the census tracts.

The CMHCs, or centers wherein psychiatric services are available, are clustered in the south central region of the city, with one center in the north central area. The south central areas are also the centers where the SL/SS families live.

Map 21 indicates the distribution of the SL/SS population in El Paso County, with Map 22 depicting the SL/SS distribution in the city proper. As can be seen from the two maps, most of the SL/SS population in El Paso County resides within the city of El Paso, with only a few (roughly 4% of the total SL/SS population) residing outside the city limits. In the city there is one census tract (hereinafter CT or tract) that is predominantly SL/SS, and four others that have high concentrations. CT 37 has the highest number of SL/SS residents in one area in El Paso, with CTs 28, 36, 38 and 39 (all along the Rio Grande) predominantly SL/SS. Of these five, only CT 28 has a CMHC within its borders.

The tracts that have between 2.5% and 3.5% of the total SL/SS population of El Paso County are in about the same areas as the five predominantly SL/SS CTs. Most of these are either

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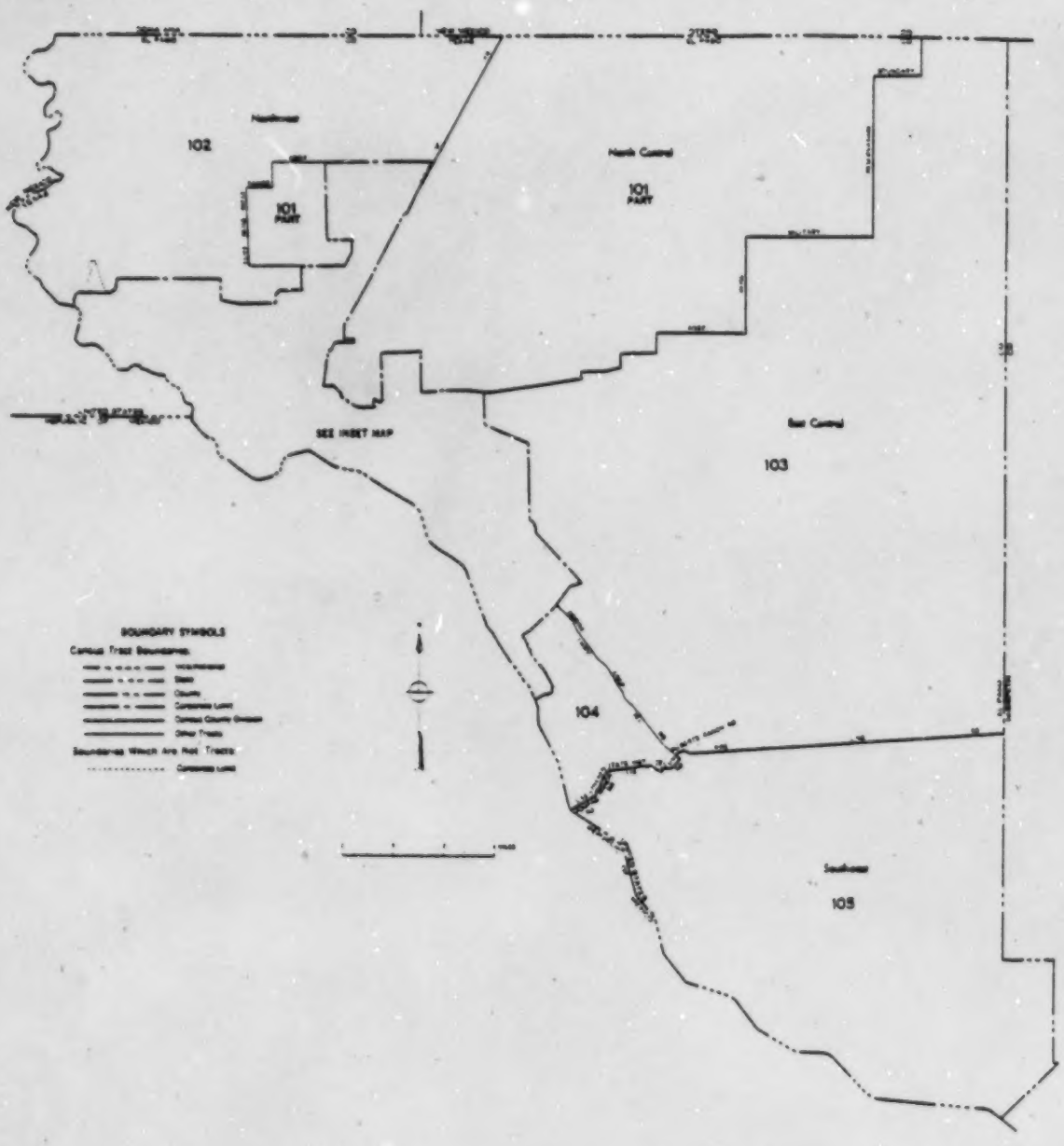
Map 19: El Paso County




U. S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1970 Census of Population and Housing
CENSUS TRACTS
EL PASO, TEX.
STANDARD METROPOLITAN STATISTICAL AREA
Final Report PHC(1)-93

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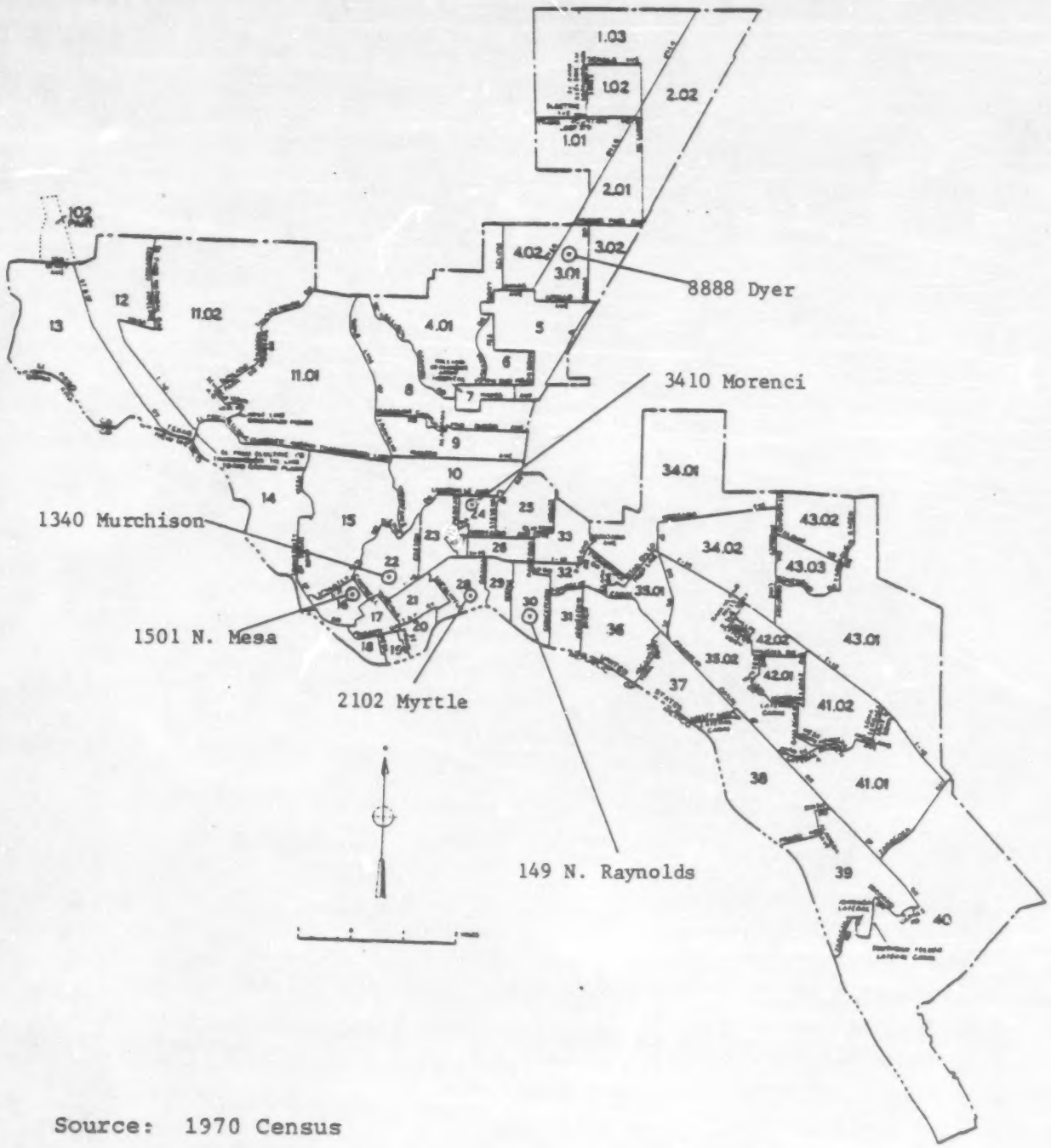
Map 20: The City of El Paso and the Centers where Mental Health Services are Available, 1970.




Source: 1970 Census

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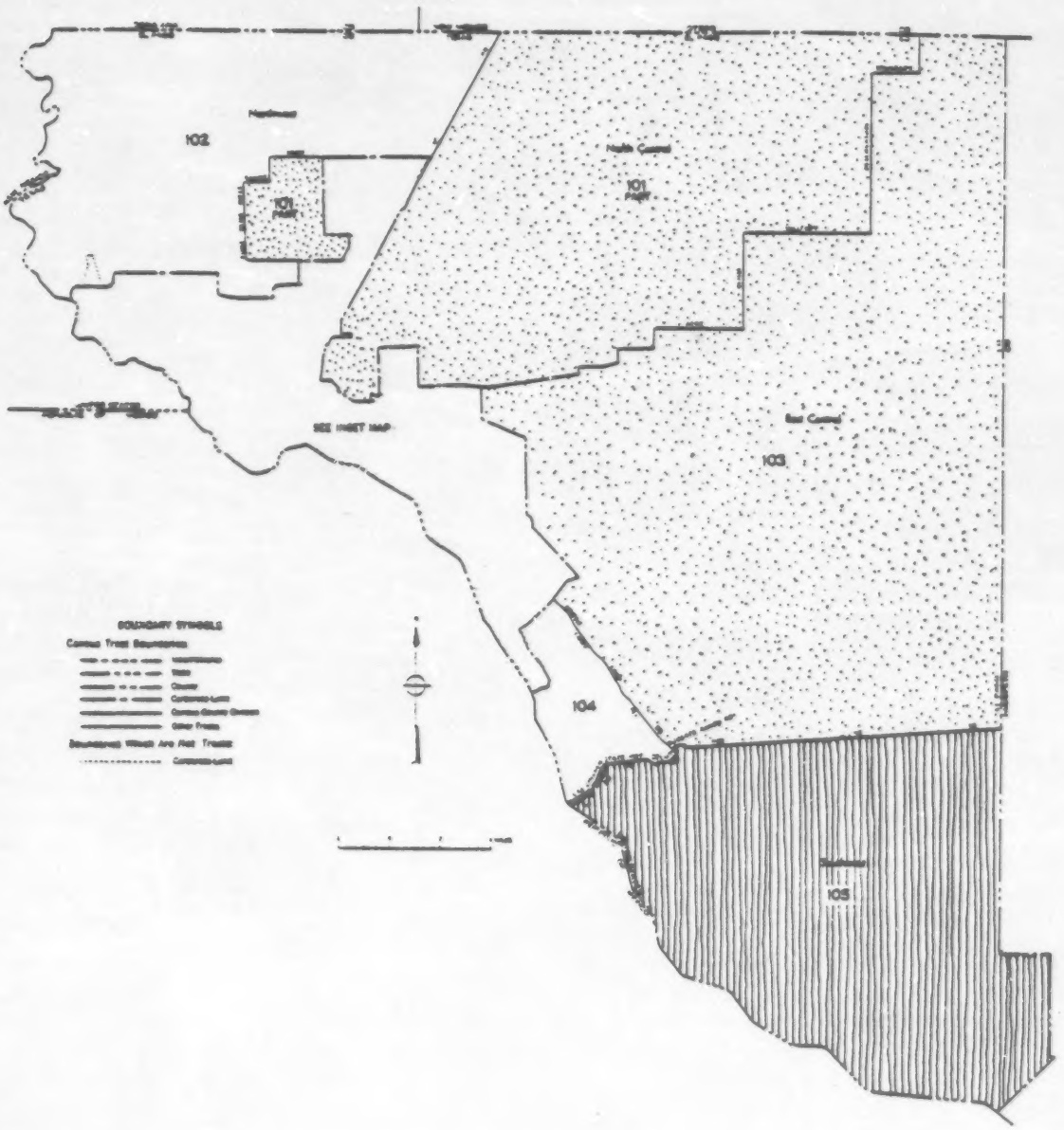
Map 21: The Distribution of the Spanish Language/Spanish Surname Population in El Paso County, excluding El Paso Proper, by Census Tracts




Legend:

1.5 to 2.49%

.5 to 1.49%

less than .5%

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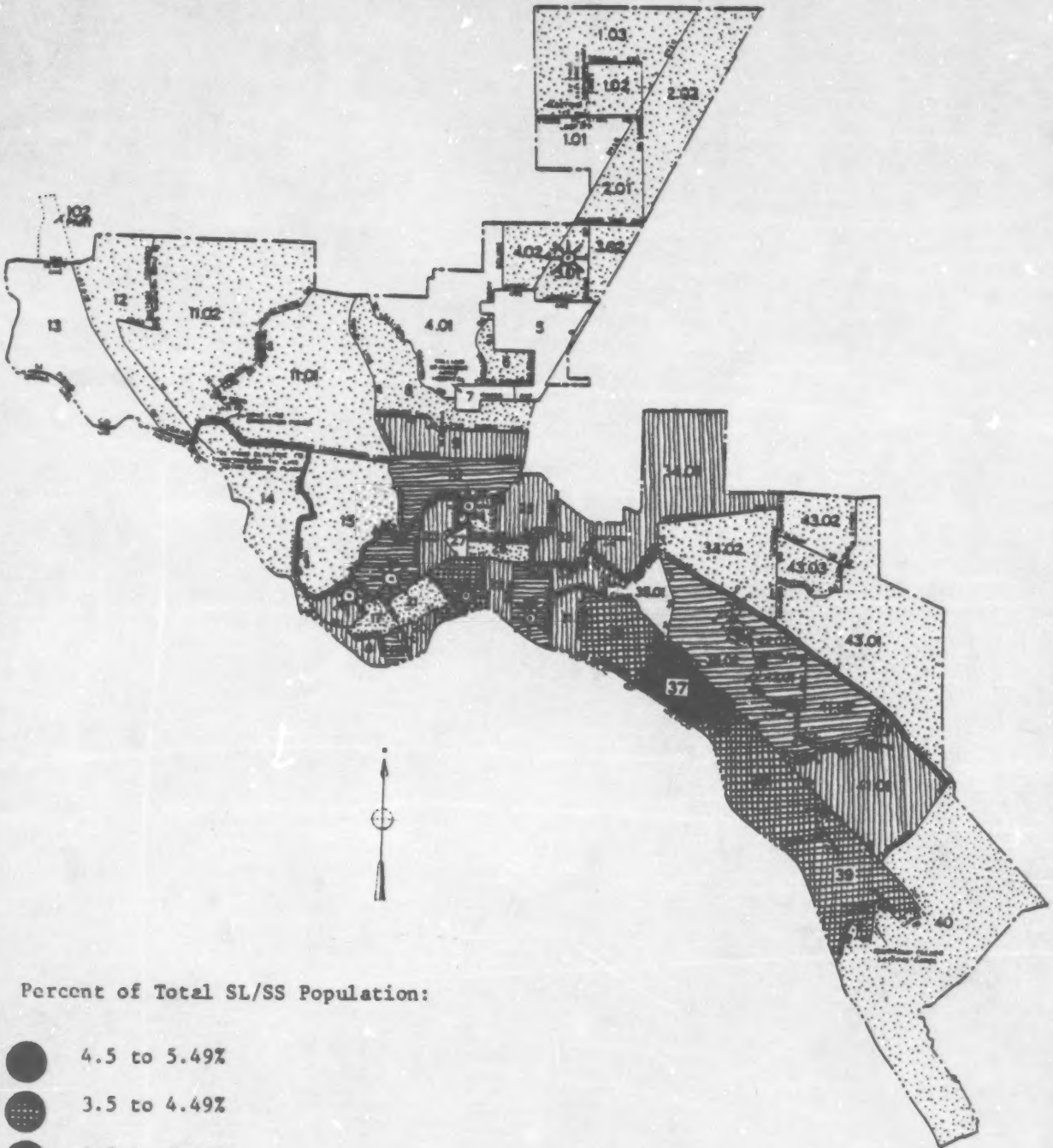
Map 22: The Distribution of the Spanish Language/Spanish Surname Population in El Paso Proper, by Census Tracts, 1970.




Percent of Total SL/SS Population:

- 4.5 to 5.49%
- 3.5 to 4.49%
- 2.5 to 3.49%
- 1.5 to 2.49%
- .5 to 1.49%
- less than .5%

Source: 1970 Census

adjoining one of the five described supra or are very close to them. Finally, the SL/SS population in general is clustered in the south central area and spread into the southeastern portion of the city of El Paso. The further away from the Rio Grande one goes, the lesser the density of SL/SS residents.

There are fifty-five CTs in the city of El Paso. Five of these house about one-forth of the city's total SL/SS population. Of these five, one CT is located in the west side (CT 28) and the rest are in the Lower Valley Area. The one tract in the downtown area that is predominantly SL/SS is just south of IH 10, between Grama Street and Eucalyptus Street. There is a CMHC at 2101 Myrtle Street, very convenient to this CT's residents. None of the other four predominantly Mexican American CTs (36, 37, 38 and 39) have a CMHC within their boundaries.

The mental health centers are located in CTs 3.01, 16, 22, 24, 28, and 30. With the exception of 3.01, all of these are predominantly SL/SS. CT 3.01 is 29.78% SL/SS and 2.4% Black. (The other five CTs have an SL/SS population as follows: CT 16 is 69.42%, CT 22 is 76.47%, 28 is 70.68%, 24 is 72.85% and 30 is 96.44%.) In other words, CT 30 has a total of 6,157 residents, 5,938 of whom are SL/SS (or 96.4%), and 1.6% Black. Thus, it safely can be said that the CMHCs are located in the central downtown area where they are more accessible to all the population of the city.

There is one small difference, however. The center that is not located in the downtown area is in CT 3.01, the north side of El Paso. This tract had a total of 5,958 residents in 1970. The four surrounding census tracts (3.02, 2.01, 4.02, and 5.0) had a total of 28,351 residents. It seems reasonable that a large group of people such as this should not have to go downtown for mental health services, but have a center nearer their homes. The only problem is that there are just as many if not more people in the Lower Valley Area. Census Tracts 36, 37, 38, and 39 alone have 38,284 people; virtually 10,000 people more, yet there is no mental health center in that area. There are only two CTs in the city that have more than 10,000 residents: CT 34.02 and CT 37. The former has 12,130 residents, 35% of whom are SL/SS, and the latter has 11,601 residents of whom 87.4% are SL/SS. If a CMHC had been placed in CT 37, then residents in CT 34.02 would be close enough to use it as well, and the populations of CTs 41.01, 41.02, 42.01, 42.02 and 35.02 could all have been very close to the center: a total of 76,105 persons. It is probable that the tendency found in the statewide inquiry of locating a new CMHC in an area already served by an accessible center may exist in El Paso also.

Finally, Map 23, the Sun City Area Transit (SCAT) bus routes, indicates that the downtown CMHCs can be reached from all areas of the city through the public transportation system. The bus routes, however, are more representative of the population clusters in that they focus more on the Lower Valley Area than the area between the Ft. Bliss Military Reservation and the Mt.

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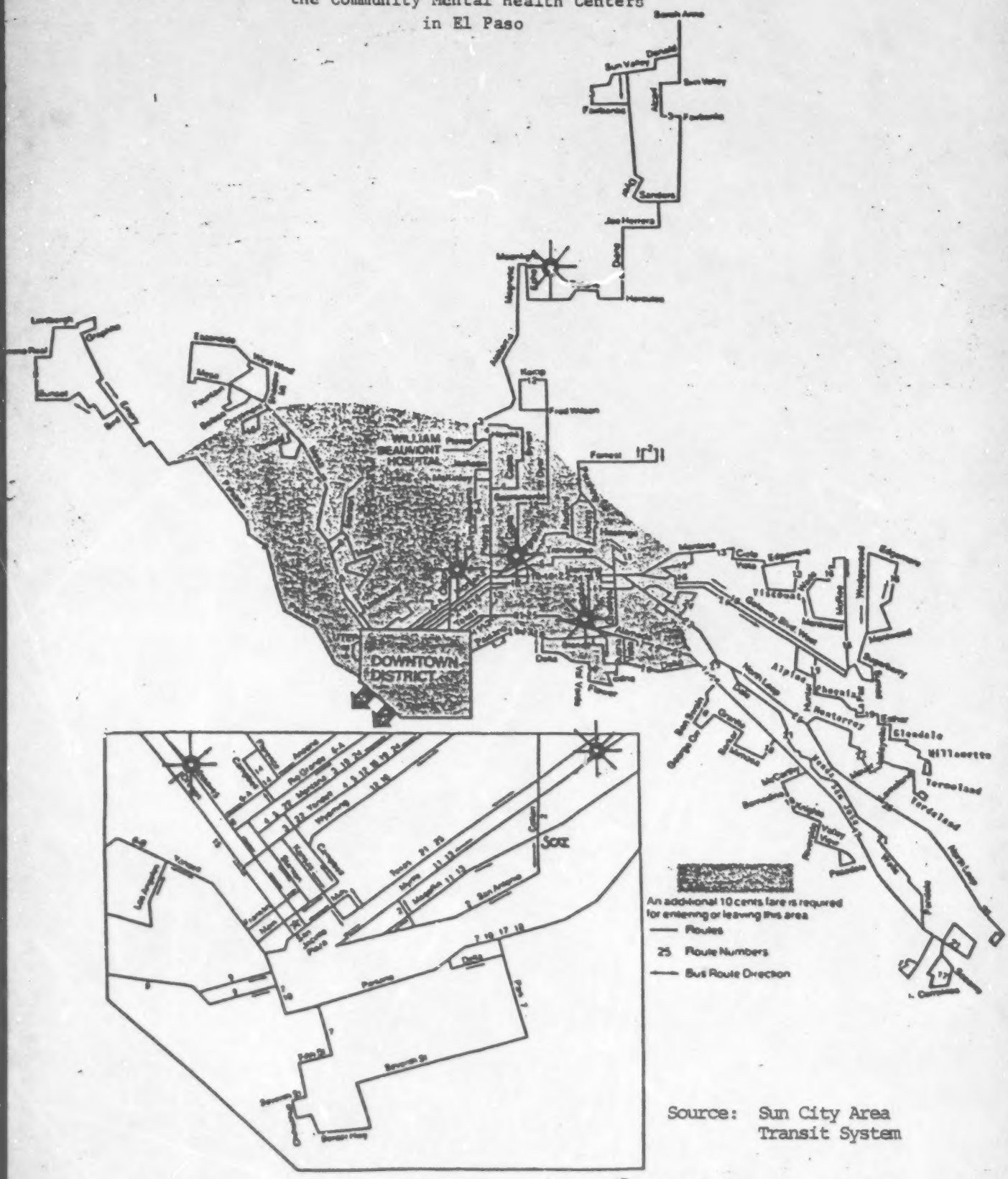
Map 23: The Sun City Area Transit System Bus Routes, 1979, and the Community Mental Health Centers in El Paso


WILLIAM BEAUMONT HOSPITAL
DOWNTOWN DISTRICT
An additional 10 cents fare is required for entering or leaving this area
Routes
25 Route Numbers
Bus Route Direction

Source: Sun City Area Transit System

Franklin Wilderness Park. Census tract 40, nonetheless, with about 3,000 residents, has little access to public transportation, and therefore, to CMHC services. CT 40 is almost exclusively SL/SS.

In conclusion, it can be said the the El Paso mental health authority has placed most of its CMHCs in the downtown area where the greatest number of people, regardless of race or national origin, can have access to them. Because of their central location, public transportation to and from the centers does not pose a problem. A small nuisance is that the persons living outside the downtown area have to pay an extra sum to enter and leave the central zone. However, this extra sum is minimal.

The only problem to which this description can allude is the fact that a CMHC was located in the predominantly Anglo region to the north of the downtown area, rather than the predominantly SL/SS regions in the Lower Valley Area. The population distributions are such that more people would have been served (in sheer numbers) if the center had been located somewhere in CT 37. This is mere speculation on the part of the author, but it is conceivable that the CMHC on Dyer Avenue is more accessible to the more affluent people, and perhaps to the staff of the CMHC, than to the clients and those indigent people the CMHC was originally intended to serve. This tendency was found in the previous section: the tendency to seek to serve those areas already served. This may not be the explicit intent of the mental health movement, but there is some indication of implicit intents

that may differ; the serving of the over-served is a case in point. One could say that one mental health center doth not a movement make, but to locate a center in an area that is conspicuously lacking in those people the center is supposed to serve is not only questionable, but reproachable.

This prima facie evidence does not lend itself to definite conclusions. However, it does encourage one to question why such a situation exists. Surely further research is called for.

Fort Worth. The city of Fort Worth is the fourth largest in the state of Texas. This metropolitan area, sometimes called Cowtown, had a population of 393,472 residents in the 1970 census. Tarrant County -- the catchment area for the Trinity Valley MHMR Authority -- had 716,317 residents. Fort Worth proper had 33,386 SL/SS residents (8.4%) while Tarrant County had a total of 42,960 SL/SS residents (6%).

The population of Tarrant County is more or less evenly distributed throughout the area. There are certain sections of the county, however, that cluster greater numbers than do others. The area to the northeast of the downtown zone, around Hurst, North Richland Hills and Halton are quite densely populated. Other centers of population, shown on Map 24, are just north and west of Arlington Lake, the River Oaks area, north and west of Lakeside Village, and the region just north of Benbrook Lake.

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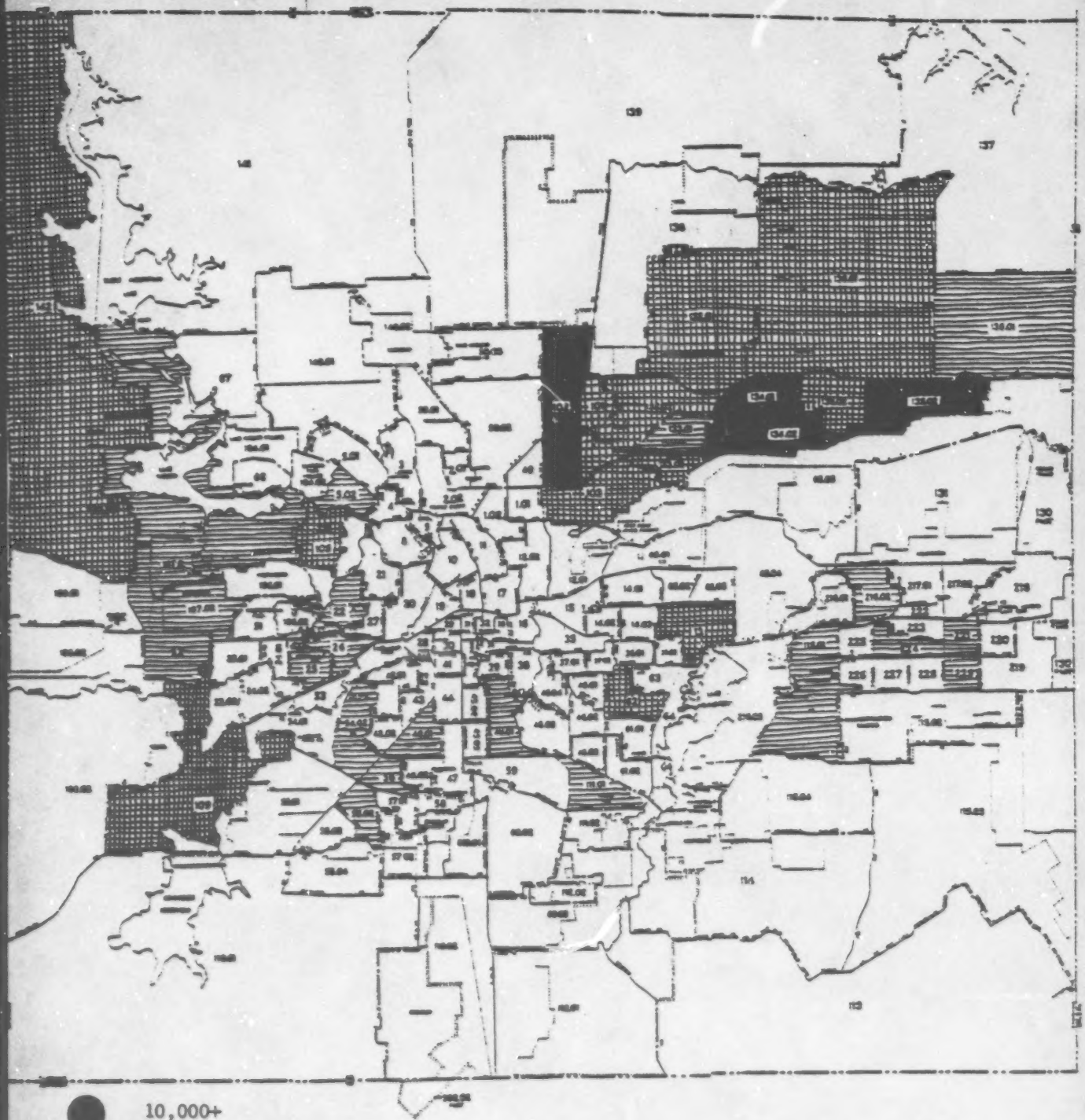
Map 24: The Population Clusters of Tarrant County, 1970.



10,000+

8,000 - 9,999

6,000 - 7,999

less than 6,000

Source: 1970 Census

The metropolitan area of Fort Worth is divided into several rather large communities that function as cities for all intents and purposes. This may account for some of the population clusters seen in Map 24, and for the fact that they cluster unevenly. It should be recalled that the general population is fairly dispersed, but the clusters tend to be in the major suburbs such as Halton and Hurst. Community mental health services from the Trinity Valley CMHCs are still available to these communities since they are within the centers' catchment area.

The CMHCs in the Trinity Valley Region are not as evenly dispersed as one might wish. While the populations seem to cluster in the suburbs, all the CMHCs are in the downtown area, save one which, while in a heavily populated area, is in the west/northwest part of the city rather than the northeast, where the populations are. Map 25 shows the locations of the five CMHCs serving the Trinity Valley area. It also indicates the population clusters, as well as the catchment areas of the county. The centers have not been located in the areas where most of the population lives, but in the central downtown area; perhaps so that through a central location they will provide access to all.

The problem is that there are four mental health centers in one catchment area, and the other four catchment areas have much less: one area with one CMHC, and three with none. The catchment area with the most residents (the north/central region) has only

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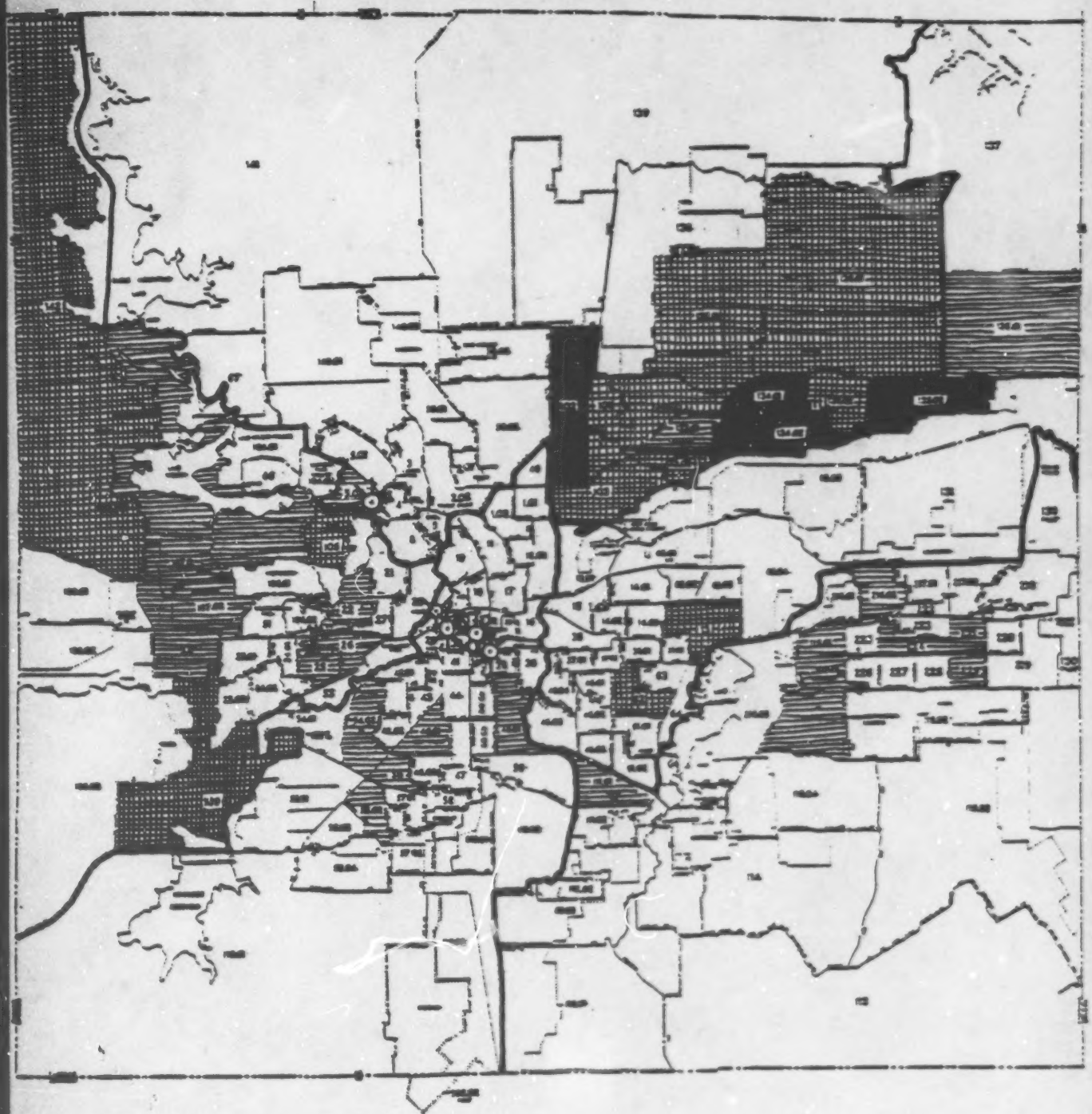
Map 25: The Trinity Valley Community Mental Health Centers and the Population Clusters of Tarrant County, divided by Catchment Areas, 1970.



one CMHC, while an area with far fewer residents has four. There is an indication of poor planning with regard to locations of the CMHCs, but this is based on prima facie evidence only.

The SL/SS population of Tarrant County is rather small (discussed supra) and located in a small area. Map 26 indicates those census tracts that have SL/SS residents in clusters of the total population; in other words, the SL/SS population of CT 2.02 envelops over 4.5% of the total SL/SS residents of Tarrant County. The CTs with the largest percentages of the county's SL/SS population are CT 45.03 (which is over 80% SL/SS), CT 9 (which also is over 80% SL/SS) and CT 2.02 (about one-fourth). Other CTs with large percentages and numbers are CTs 3, 4 and 8. CT 10 has about 3% of the total SL/SS population and is about 50% SL/SS residents. Finally, four other census tracts have some larger representations of the populations. These are 48.01, where Southwestern Baptist Theological Seminary is located, 45.02 and 40, very near the downtown area, and 50.01 in the northwestern part of the city. Generally speaking, the SL/SS population is in the area around the Fort Worth Stock Yards and Rockwood Park, with some clusters closer to downtown. There is one mental health center in CT 5.02 that is very close to a large representation of the SL/SS population. The other four, centrally located for convenience, are accessible to the community in general and to the SL/SS population as well.

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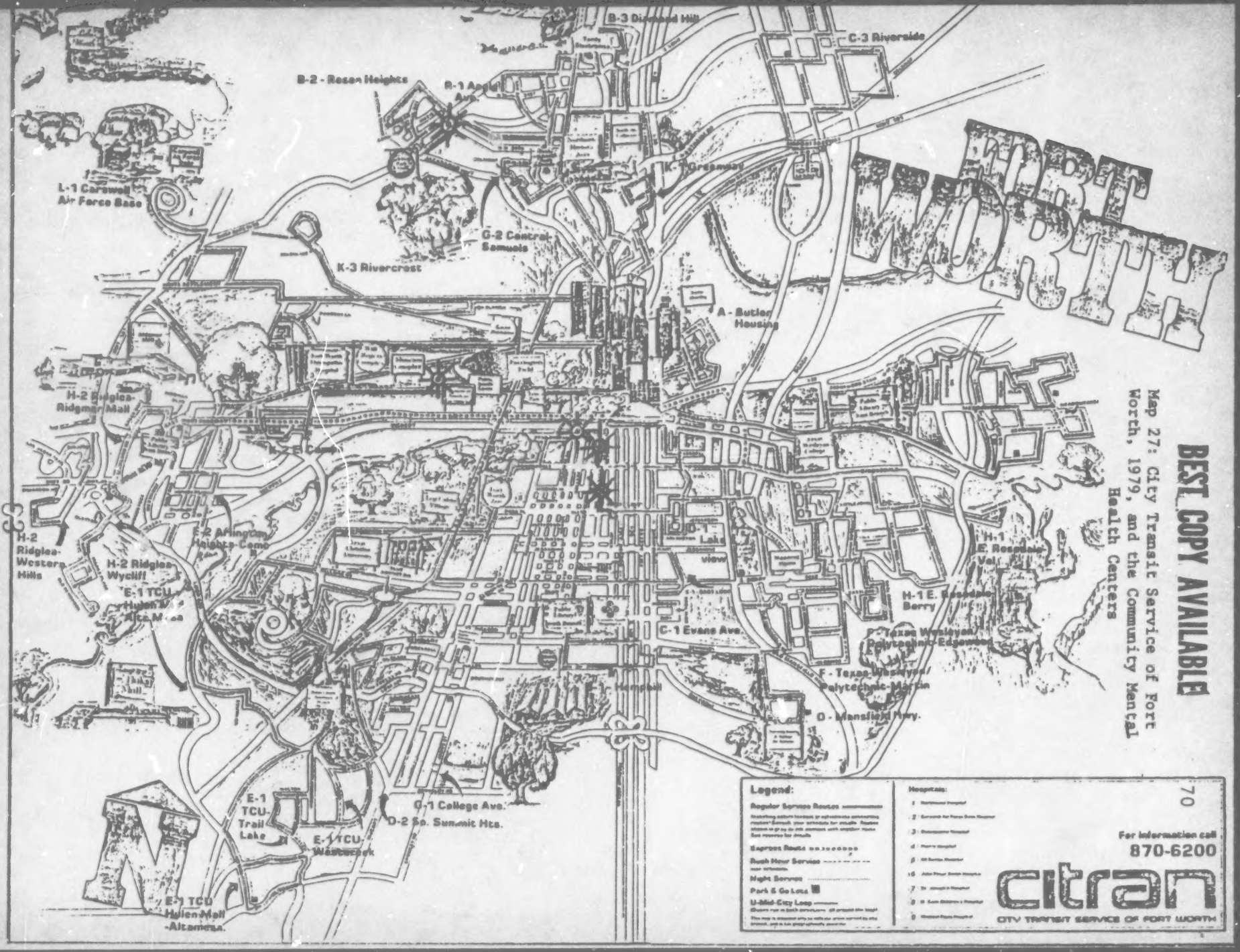
Map 26: The Distribution of the Spanish Language/Spanish Surname Population of Tarrant County, as a Percent of the Total Population and the Community Mental Health Centers, with Catchment Areas, 1970.

Information obtained from CITRAN, the City Transit Service of Fort Worth, indicates that public transportation to and from the CMHCs is available to all the predominantly SL/SS tracts. Map 27, the CITRAN bus routes, indicates that, while there is no abundance of bus routes, the major centers of the city have been covered so that public transportation is available from the SL/SS neighborhoods to the CMHCs. Some walking is involved, but nothing major, in order to reach the centers from the bus stops. There is more walking involved in order to reach certain streets of the SL/SS neighborhood from the bus stop, but again, not an inordinate amount for the average person.

In concluding the Fort Worth review, it can be said with certainty that the four centrally located CMHCs are accessible to the entire community because of their central location. It seems that the population centers are rather removed from the downtown area, but these population centers are the suburban cities previously described so it is highly possible that some of these people would not require CMHC services, preferring instead to use the services of a private practitioner. There is no evidence to indicate a preference in this study, but general knowledge about mental health services is that people who live in the suburbs generally avoid health facilities frequented by the indigent and/or ethnic minorities. It seems reasonable to conclude that the central location provides greater accessibility to those who need it most. Based on first glance evidence, the CMHCs are accessible to SL/SS persons in Fort Worth but, as said previously, further studies may be necessary before this observation can be substantiated.


FORT WORTH
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Map 27: City Transit Service of Fort Worth, 1979, and the Community Mental Health Centers
B-3 Diamond Hill
C-3 Riverside
B-2 - Rosen Heights
R-1 Apollo Ave.
K-1 Greenway
L-1 Carswell Air Force Base
G-2 Central Samuels
K-3 Rivercrest
A - Butler Housing
H-2 Ridglea-Ridgmar Mall
H-2 Ridglea-Western Hills
H-2 Ridglea-Wycliff
E-2 Arlington Heights-Camp
E-1 TCU-Helen Mall-Alta Mesa
D-1 Lake view
C-1 Evans Ave.
H-1 E. Rosedale Berry
H-1 E. Rosedale Val
F - Texas Wesleyan Polytechnic-Edgewood
F - Texas Wesleyan Polytechnic-Martin
D - Mansfield Hwy.
E-1 TCU-Trail Lake
E-1 TCU-Westcreek
G-1 College Ave.
D-2 So. Summit Hts.
E-1 TCU Helen Mall -Altamesa
Legend:
Regular Service Routes
Express Route
Rush Hour Service
Night Service
Park & Go Lots
U-Mid-City Loop
Hospitals:
For information call
870-6200
citran
CITY TRANSIT SERVICE OF FORT WORTH

San Antonio. The "Alamo City" had a total of 654,153 residents in the 1970 census; 341,333 (52.18%) were SL/SS. The same census determined a sum population of 830,460 residents in Bexar County, 376,027 (45%) of whom were SL/SS. The fact that the city proper is 52% SL/SS is particularly significant in planning and providing mental health services for this ethnic group, which is universally recognized as one of America's underprivileged minorities and, therefore, more prone to suffer extreme stress. It would be expected that, in keeping with the original intent of the law, this city would figure prominently in the CMHC movement because of its services to such a large percentage of its catchment area.

The population of Bexar County is heavily concentrated within San Antonio. Regarding this heavy concentration, some explanations are necessary. The most densely populated census tract in the city is CT 1614, with over 20,000 residents. However, these people are residents of Kelly and Lackland Air Force Bases. Since Lackland is the largest Air Force training base in the world, one would expect a high density here. But this population is also highly transient since the majority of the trainees leave the base within a few weeks after their arrival. Thus, CT 1614 has not been included in the description.

The same is true of CT 1201, which consists mostly of Fort Sam Houston, one of the largest military training centers in the world; therefore, this tract will not be included. On the other hand, there are several suburban communities, such as Alamo

Heights, Terrell Hills and Olmos Park, that cannot be counted as part of the city, but are nonetheless within Bexar County, so they have been included as eligible to receive CMHC services.

Map 28 presents the heavier population clusters of the city. If one were to draw an imaginary line from the southwest corner of CT 1101 straight north and south, and from that same corner straight east and west, the city would thus be divided into quadrants. The majority of the population can thus be seen as being to the west side of the city, distributed into roughly three areas: the northwest, the central west and the southwest. There are definite divisions between each of the three (note that CT 1706, 1705 and 1901 divide the northwest from the west central, and that 1604, 1603, 1504 and 1503 divide west central from the southwest. Each of these seven census tracts has less than 6,000 residents, yet is very near, if not always adjacent to, a densely populated tract). The eastern half of the city has two more heavily populated areas, each rather small and well contained. In the northeast, there is only one heavily populated area: CT 1205, the area just north and east of Fort Sam Houston. Another more populated area, though not as densely populated as CT 1205, is CT 1414, just northeast and east of Brooks Air Force Base. Most of this population is contained in a community called Highland Hills.

It is also apparent from Map 28 that the population of San Antonio, even in 1970, is centered more north than south (this is much more the case at present). Even CT 1704, a heavily populated

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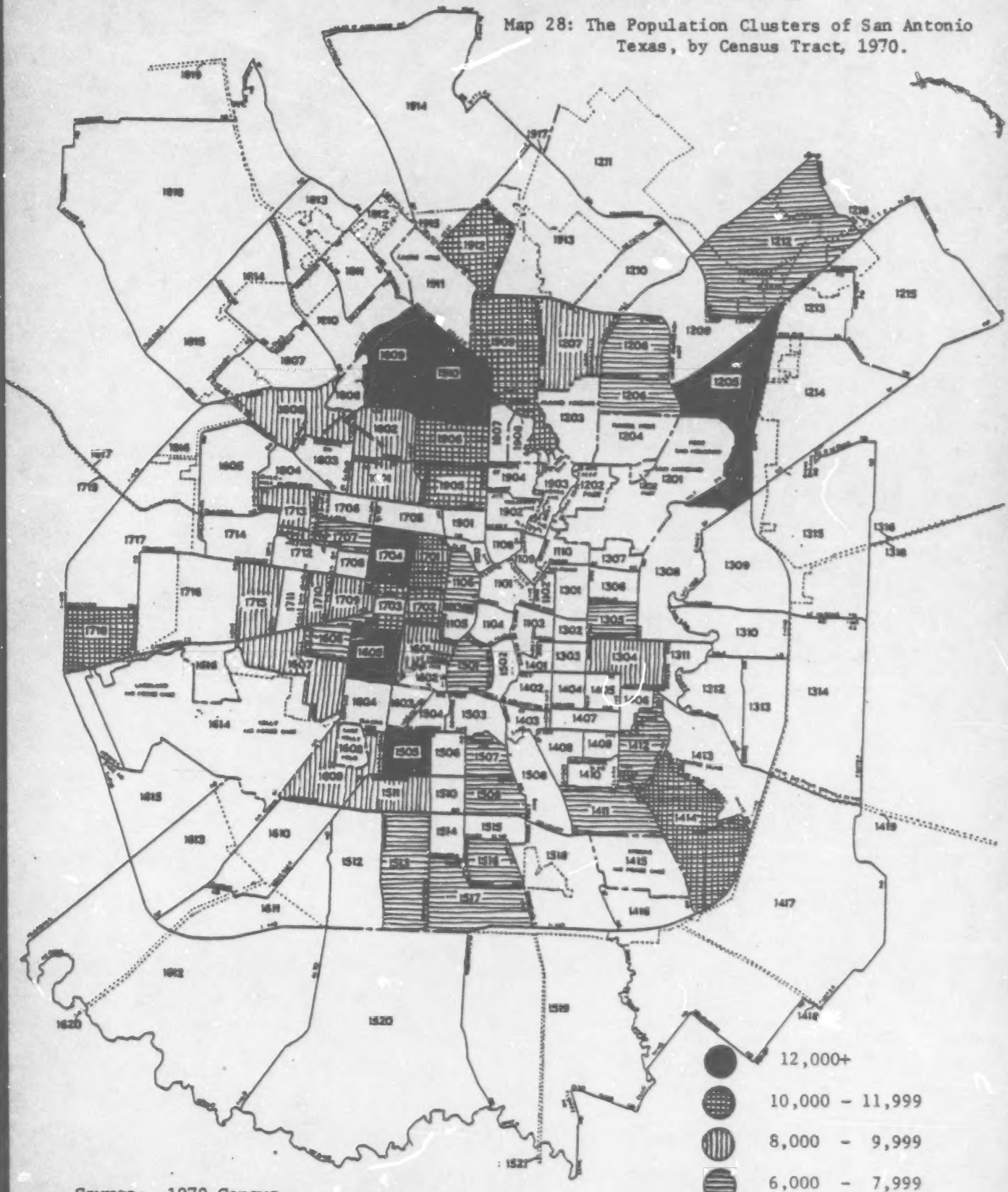
Map 28: The Population Clusters of San Antonio Texas, by Census Tract, 1970.




Source: 1970 Census

tract, is very near the dividing line between north and south, but is considered northwest. Thus, the heavy concentrations of people are in the northwest and in the west central parts of the city.

Map 29 locates the CMHCs with relation to the population clusters in the city. Out of the six census tracts in the city with over 12,000 residents, two have a mental health center in their midst. These are CT 1704 and CT 1501. The other four do not have centers inside their boundaries. The rest of the ten centers in the city are located throughout all four quadrants (recall the imaginary lines dividing the city into four sections). The northwest quadrant has the most centers with five, the southeast and southwest have two each and the northeast has only one. Regarding the northeast part of town, as previously mentioned, CT 1205 is composed primarily of military or military-related persons who may have access to Fort Sam Houston's services. Also, San Antonio's northeast section is the most expensive quadrant of the city in which to live, so perhaps this area has an over representation of professionals and persons who would not use CMHCs but would prefer seeing a private practitioner. While this is only speculation, it could explain why CMHCs seem to avoid that quadrant.

The entire south side has only four locations where mental health services can be obtained by the poor. Fortunately, Wesley Community Center, which contracts with Bexar County Mental Health and Mental Retardation Center, is located in CT 1505, a densely populated, lower-middle and lower-class neighborhood. It is true

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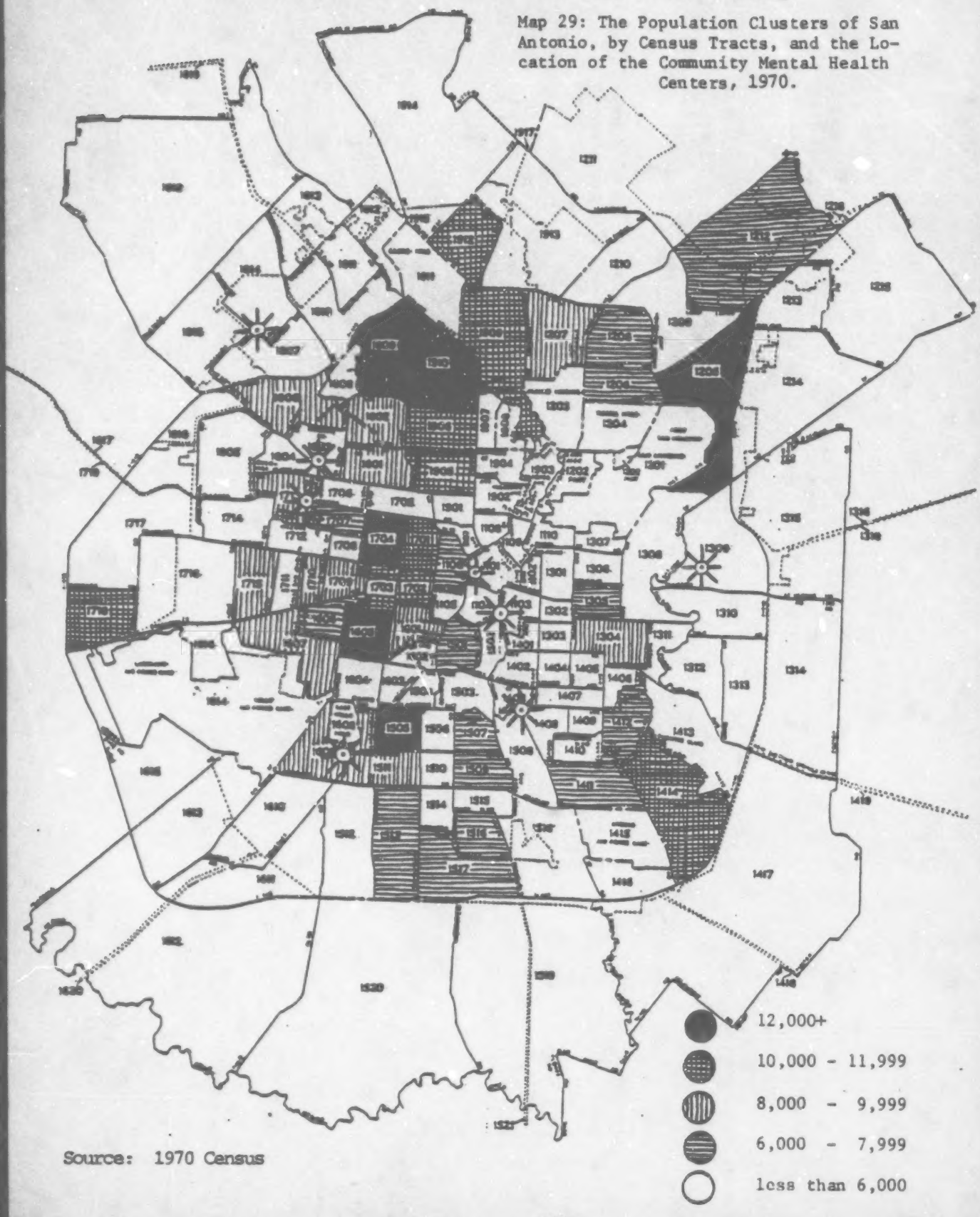
Map 29: The Population Clusters of San Antonio, by Census Tracts, and the Location of the Community Mental Health Centers, 1970.




Source: 1970 Census

that the southern half of the city has less people than the northern half, nonetheless, the people in the south side may be underserved when it comes to mental health services. Consider the following information, for example.

The northwest quadrant of San Antonio and Bexar County is rich in services. Being the location for the Southwest Texas Medical Center, there is an abundance of quality, though not always inexpensive, health care. Since there are two census tracts adjacent to each other with over 12,000 residents each in this area, this provides accessible care to the northeast quadrant of the city.

The problem is that the more affluent neighborhoods in San Antonio are all on the northern half of the city -- the extreme northern edges to be exact. If one lives in the northwestern side of the city, mental health services are easily accessible. If one lives in the southern half of the city, a much less affluent part of town, accessibility may present a problem.

Map 30 presents the distribution of the SL/SS population throughout the city and the location of the CMHCs. The distribution of the SL/SS residents herein described is a combination of density and ethnicity. In other words, a census tract such as 1605 contains about 3% of all the SL/SS persons in San Antonio, whereas 1601 contains about 2% of the total; however, both tracts are about 95% SL/SS. Thus, the distribution is by sheer numbers as a percent of the total population of the city.

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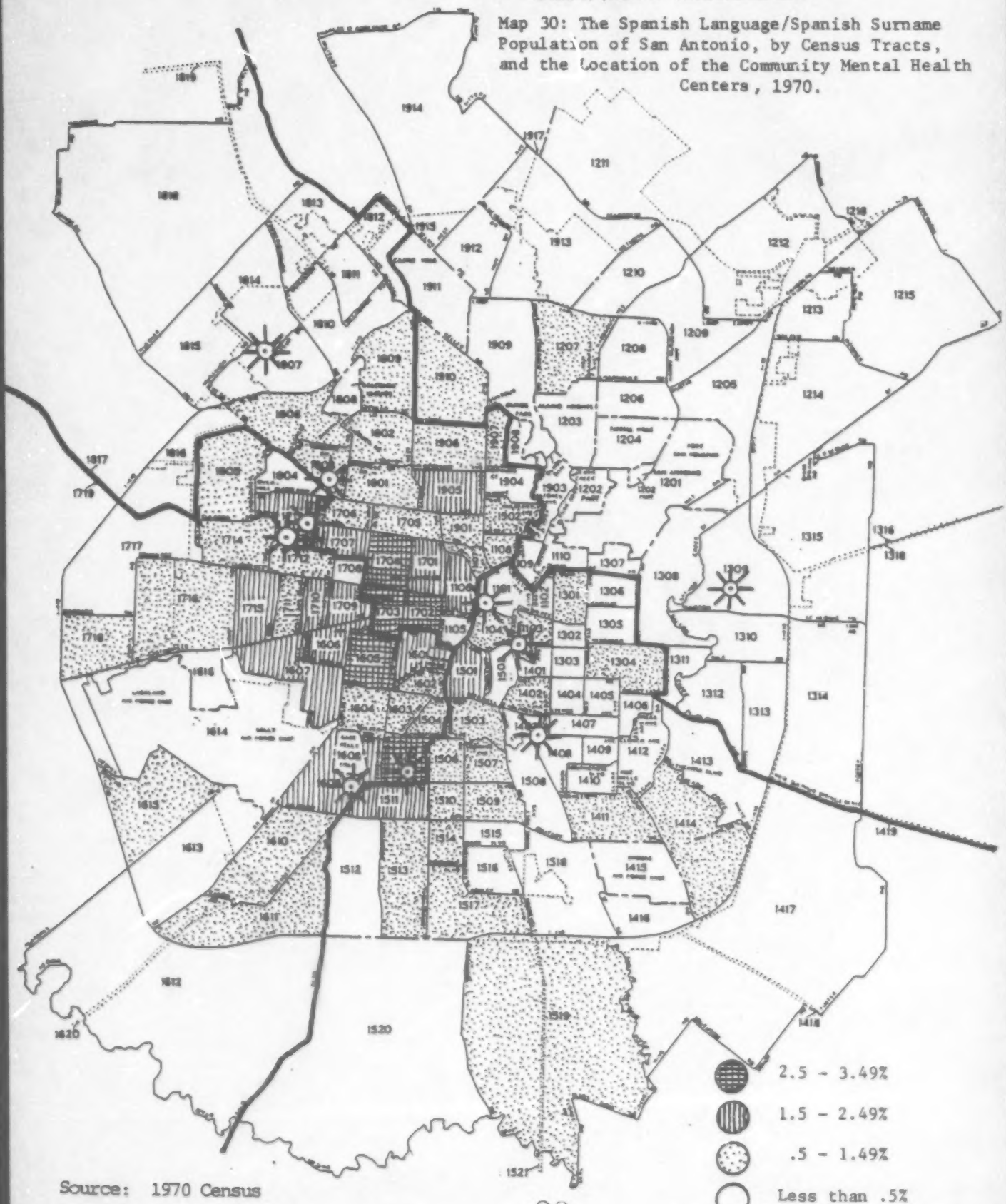
Map 30: The Spanish Language/Spanish Surname Population of San Antonio, by Census Tracts, and the Location of the Community Mental Health Centers, 1970.




Source: 1970 Census

It is quickly evident from looking at Map 30 that the west central area is the place where most SL/SS people in Bexar County live. There are a few clusters in the southwestern part of the city (tracts 1505 and, less so, 1609 and 1511) and some in the northwest quadrant (CT 1905). Even in the general city-wide distribution, the SL/SS residents stay to the west side; if the city were divided into an eastern and a western half, the majority of the SL/SS persons would be in the west side. There is only one tract in the affluent northeast quadrant that has a goodly representation of SL/SS people: CT 1207 in the Cementville area. Other than that, the northeast section of town remains largely segregated.

The CMHCs on Map 30 present an interesting phenomenon. The predominantly SL/SS section of town has four CMHCs: all located at the outer edges. CT 1713 has two locations close to each other in the northern edge of the SL/SS communities, and CTs 1609 and 1505 have one each in the southern edge of the community. Recalling Map 26 for a moment, three out of the four CMHCs are located in tracts that are not as populated by SL/SS people as others. The one exception, again, is the Wesley Community Center in CT 1505, a heavily crowded, predominantly SL/SS community. Other than Wesley and the other three centers in the west central area, the rest of the six CMHCs are not readily accessible to the SL/SS community. The center in CT 1102 is closer to the predominantly SL/SS tracts than any other (CTs 1702, 1703, 1704 and 1605), but it is in another catchment area.

The city is divided into four catchment areas. These four divisions are, more or less, the same as the four quadrants. However, the predominantly SL/SS census tracts have to report to CMHCs that are a considerable distance away. Certainly there are some mental health services in the area (e.g., Robert B. Green Hospital has a psychiatric unit) but they are not the community focused, community-oriented approach that a CMHC offers. In order to receive CMHC-type of services, persons living in the predominantly SL/SS census tracts have to travel a considerable distance.

Map 31, the bus routes of the VIA Transit System in San Antonio, outlines the transportation problems between the SL/SS community and the CMHCs. In order for the majority of the SL/SS clients who require public transportation to arrive at the CMHC, they must go to the downtown area, obtain a transfer, wait for another bus, and ride the second bus to the center. The same procedure must be repeated to return. This process could become quite lengthy and involved, consequently discouraging all but the most determined from using the CMHC.

The two centers in the extreme northern edge of the SL/SS community are equally inaccessible by bus to those who live in that catchment area. A comparison of Maps 30 and 31 indicates that the people in the catchment areas of these two centers also must ride the bus downtown and return to an area very near their own neighborhood, but too far to walk.

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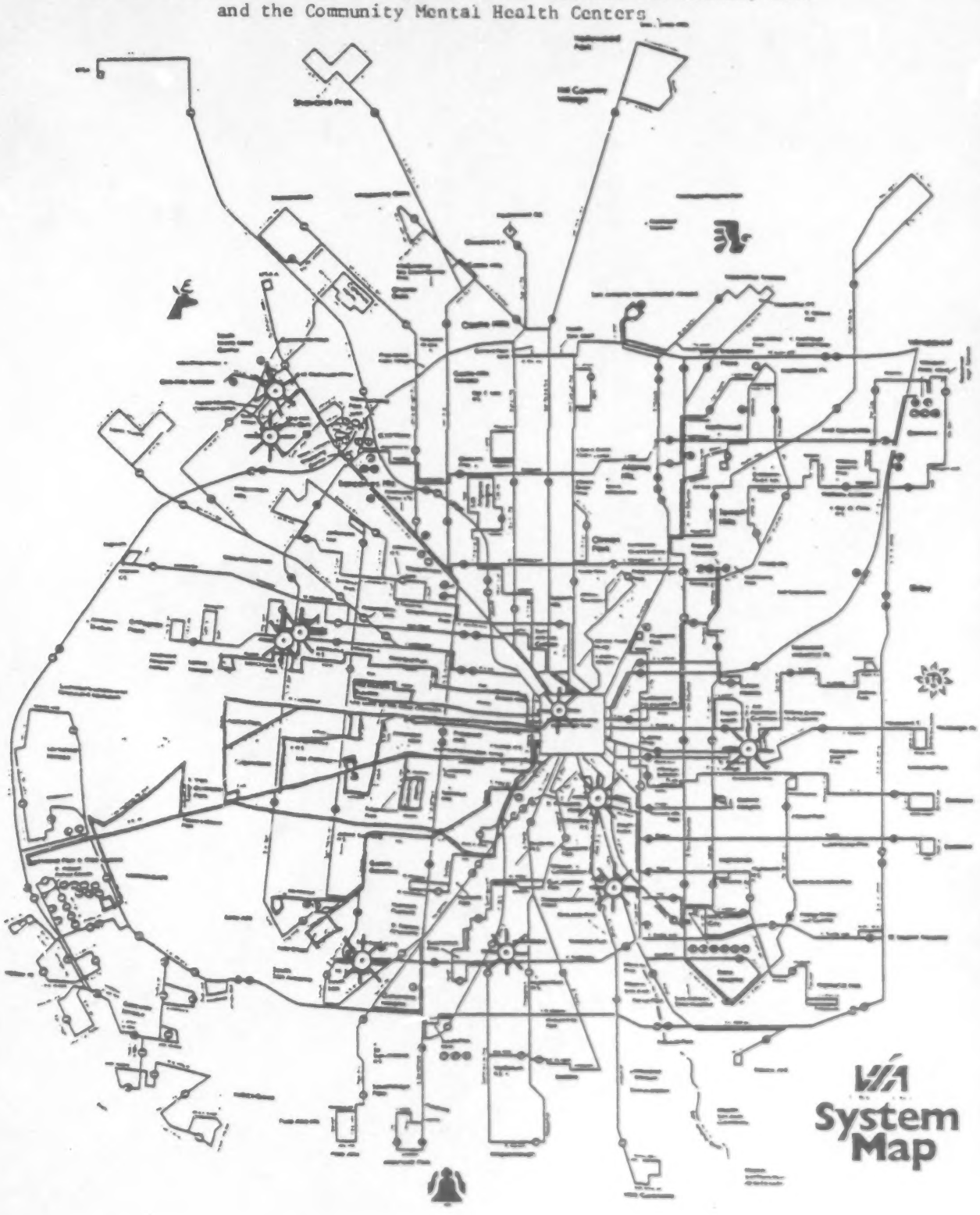
Map 31: Metropolitan Transit System of San Antonio Bus Routes, 1979
and the Community Mental Health Centers



The two centers in the southern edge are more convenient. One is right on the bus line and the other is very near it (within two or three blocks); however, the centers are still quite inconvenient to the majority of their clientele who require public transportation. The same problem that exists for others, VIZ., needing to ride downtown and then back to get to a place close to their neighborhood but too far to walk, exists for a large number of their clients also.

In concluding the description of services for Bexar County, it seems that the predominantly Anglo middle and upper-middle class quadrant of the northwest has most of the CMHCs. Efforts to balance out this phenomenon by dividing the city into four catchment areas that will more evenly distribute the CMHCs have not been entirely successful. What has resulted instead is that those people who must use public transportation have to ride a series of different buses on different bus lines to get to and from the CMHC. While the CMHCs have been concentrated in the area where the population clusters (the northwest), there are other areas where population clusters have not been as effectively served by the CMHCs. This is especially true of the west central area which is predominantly SL/SS.

Once again, here is evidence that suggests a pattern could exist. In this case, the CMHCs have concentrated in an Anglo part of town, and those that have been located on the edges of the SL/SS community are difficult to reach by public transportation. This poor accessibility could conceivably result in an underutilization of the centers by the SL/SS.

Dallas. Dallas is the second largest city in the state, and the center for much of the state's industrial, cosmetic and health industries. In 1970, the city of Dallas had 844,401 residents, 67,902 (8.04%) of whom were SL/SS. Dallas County, the catchment area for the Dallas County MHMR Centers had a total of 1,327,320 residents, 7%, or 88,652 of whom were SL/SS. The SL/SS population of Dallas proper and of Dallas County as well are a small minority.

Dallas, being a large metropolitan county, has several census tracts with more than 12,000 persons: ten to be exact. Map 32 depicts this fact. These ten tracts are well scattered in the outer areas of the city, with none being in the downtown region. If one uses the southern-most tip of CT 29 as a center point and draws imaginary lines directly north/south and east/west of this point, the city is about equally divided into quadrants. The northeast, northwest and southwest quadrants of the city have approximately equal population representations, and the southeast quadrant is the least populated area of all. There is only one census tract in southeast Dallas County that has a dense population: CT 91.02. Otherwise, there are no heavy population clusters in southwestern Dallas county. While studying the map could tempt one to conclude that the northeastern quadrant is the most densely populated, a closer look at the northwestern quadrant, with CTs 144 and 101, and the southwestern quadrant, with CTs 110 and 111.02, would indicate otherwise. It seems, then, that the population of Dallas County is distributed densely through three quadrants, with one quadrant having more room to stretch.

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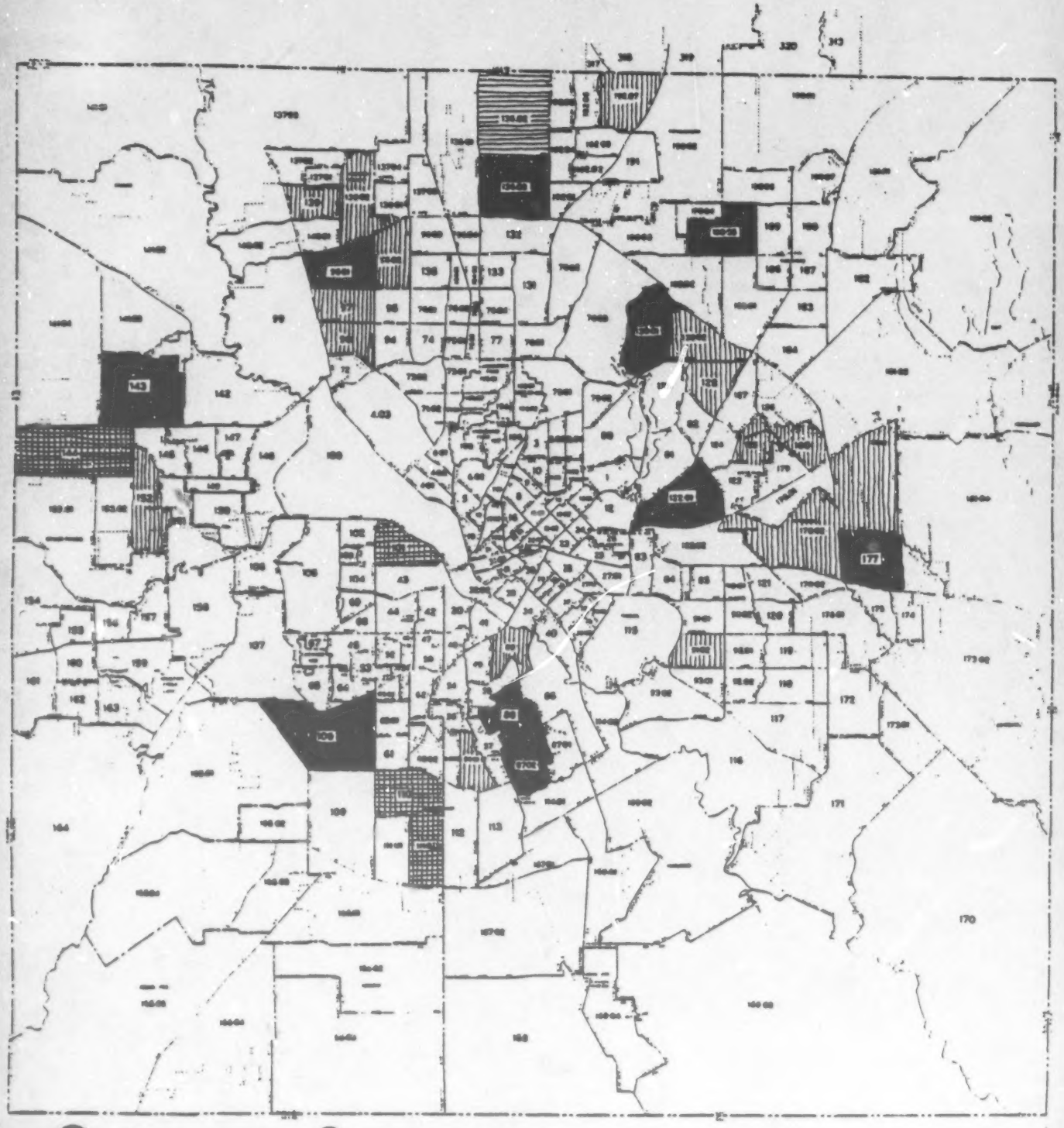
Map 32: The Population Clusters of Dallas, by Census Tracts, 1970.




12,000+

10,000 - 11,999

8,000 - 9,999

less than 8,000

NOTE: C.T. 143 has over 22,000 residents

Source: 1970 Census

Map 33 indicates the population clusters and the location of the CMHCs. All of them are located on the western half of the city! There are five in the northwest and three in the southwestern quadrant of the city. None are located in any of the ten most densely populated areas, or within any census tract that has more than 8,000 residents. There are relatively few centers anywhere near the more heavily populated areas. It would almost seem as if an effort were made to avoid the populaces, but this is based only on appearances. The fact that the three centers in the southwestern quadrant are very near each other rather than scattered among the heavy populations could indicate such an effort. This may have been done to enhance communication between the centers, facilitate exchange of information and experts, etc. Still, one cannot help but wonder about the arrangement of the CMHCs in relation to the population clusters in the city.

The fact that the SL/SS population of Dallas County is rather small (7%) has already been established. As usual, the author is more concerned with the distribution of this population due to the specific requirements of PL 93-64. There are only a few areas in Dallas County that are predominantly SL/SS. Most census tracts that have any kind of representation of SL/SS men and women have less than 0.5% of the total SL/SS population in Dallas County. Map 34 portrays this.

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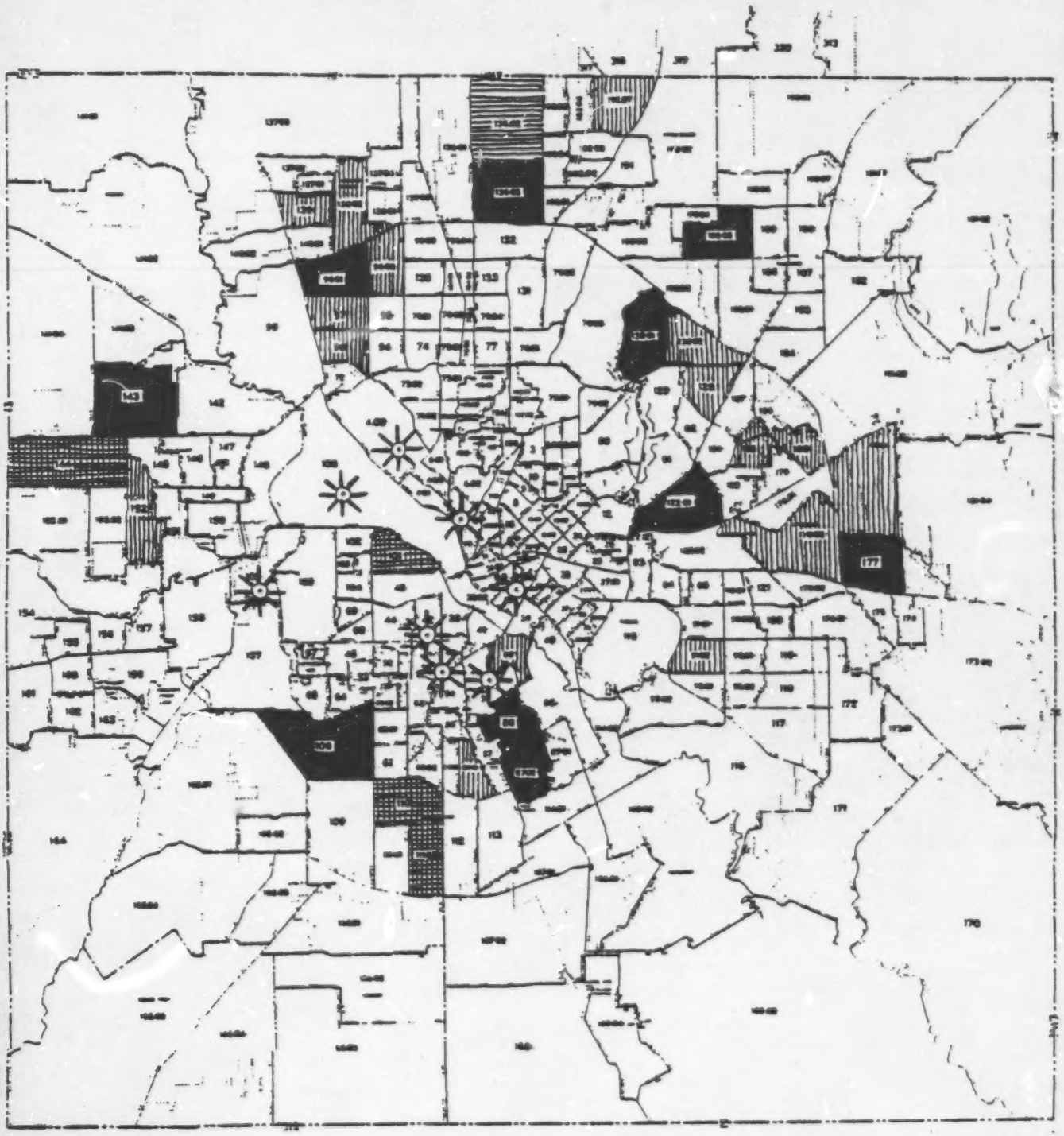
Map 33: The Population Clusters of Dallas, by Census Tracts, and the Location of the Community Mental Health Centers, 1970.



12,000+

10,000 - 11,999

8,000 - 9,999

less than 8,000

NOTE: C.T. 143 has over 22,000 residents

Source: 1970 Census

There are only a few census tracts with large representations of SL/SS persons. Particularly large representations are in CT 106, with CT 101 close behind. The greatest concentration of the SL/SS population is in CT 106, which contains approximately 5% of the total SL/SS population of Dallas County. The other clusters are in CT 101, with a large conglomeration along tracts 4.01, 4.03 and 94, and census tracts 18 and 8 nearly as large. These seven census tracts are the most densely SL/SS in Dallas County. There are other tracts with smaller portions of the total population dispersed throughout the county, with groupings in the east-central and northwestern part. The fact that Dallas County has very few SL/SS people becomes quickly evident upon locking at this map.The CMHCs seem to be quite accessible to the SL/SS community. It is important to note that there is a CMHC in CT 106, the most densely SL/SS census tract. It is also significant that CT 4.03 has a CMHC within its borders. CT 18 has a CMHC very close by in CT 5, but there are oftentimes too many "other factors" in measuring accessibility across census tracts to say that proximity indicates accessibility. This same problem for instance, is seen in CTs 100 and 101 where the former has a CMHC and the latter does not. It could be that CT 101 is divided by much more than census tract lines from the CMHC.

While an argument may be made that the placement of a CMHC within the same census tract as those that are predominantly SL/SS in order to serve those SL/SS populations efficiently is not necessary, the premise of the author is that the crossing of census tract borders may involve hardships. This is based on personal experience.

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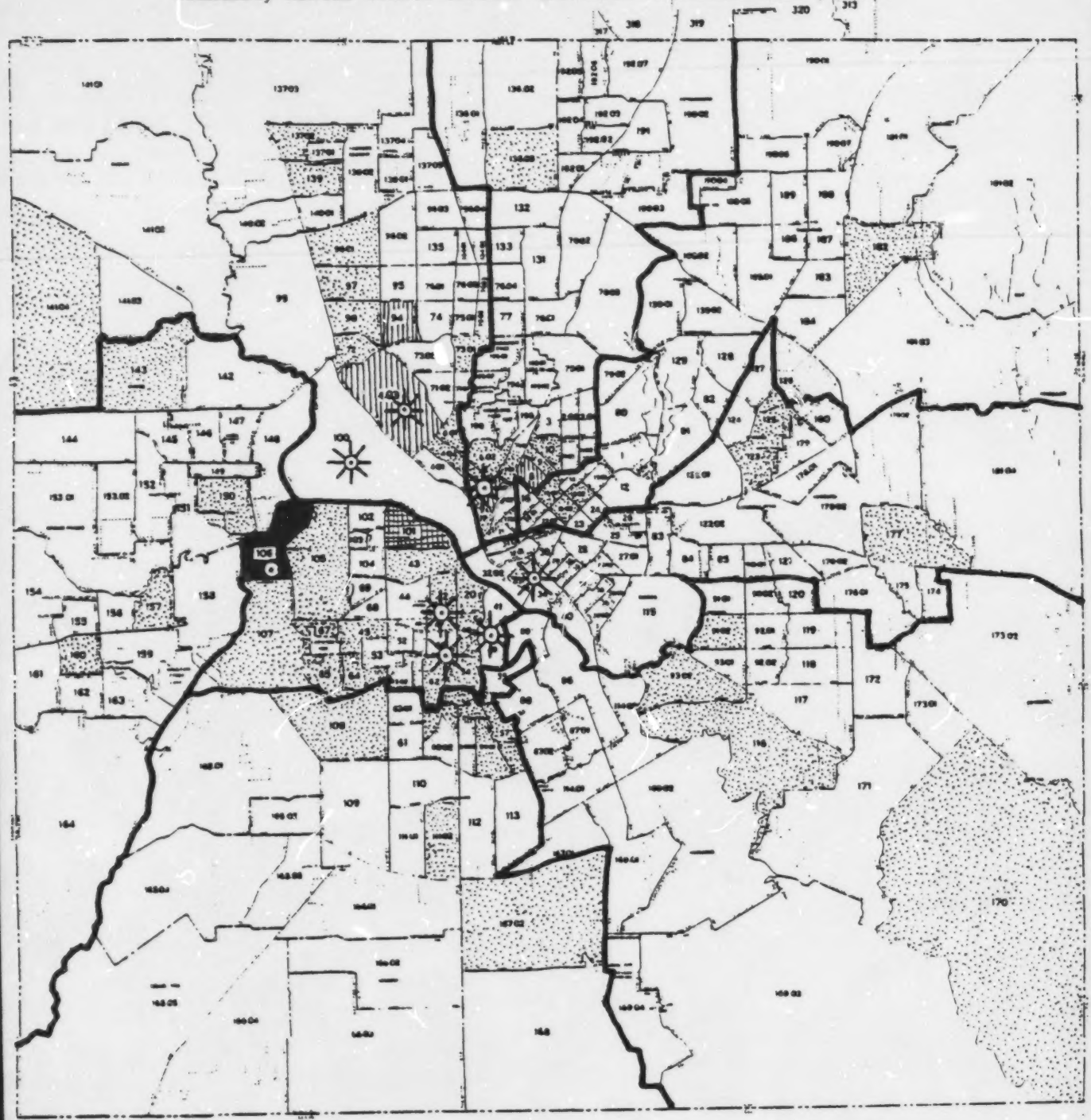
Map 34: The Distribution of the Spanish Language/Spanish Surname Population of Dallas County, by Census Tracts, with Locations of the Community Mental Health Centers and their Catchment Areas, 1970.



4.5 - 5.49%
3.5 - 4.49%
2.5 - 3.39%
1.5 - 2.29%
.5 - 1.49%
less than .5%

Source: 1970 Census

The author grew up in what is now called a blighted, indigent "barrio" (barrio means neighborhood, we spoke of all kinds of barrios back then, the Anglo barrio - or neighborhood - the upper class barrio, etc.). Our recreational facilities in the neighborhood were very limited. However, just a few blocks away from the San Juan Courts were the Cassiano Courts, wherein they had a swimming pool. The city never saw any need for building another public pool so close to an existing one, despite the fact that we wanted one. However close that pool was, it was in another "turf" where a different gang ruled and where different communities congregated. For one of us to go only a few blocks to use the swimming pool would have been unthinkable. It was not our turf!

While the gangland situation may have changed, and while the circumstances are different in every community, it is still the premise of the author that leaving one's own neighborhood for services is not only undesirable, but in many SL/SS communities, it is highly impractical. For that reason, CMHCs located in CTs adjacent to the predominantly SL/SS census tracts cannot conclusively be considered accessible, but merely close by.

There is no way to determine the territoriality of communities in this description. However, it should be pointed out that such territoriality exists in large cities and that the author is aware of it but cannot at this time control for it.

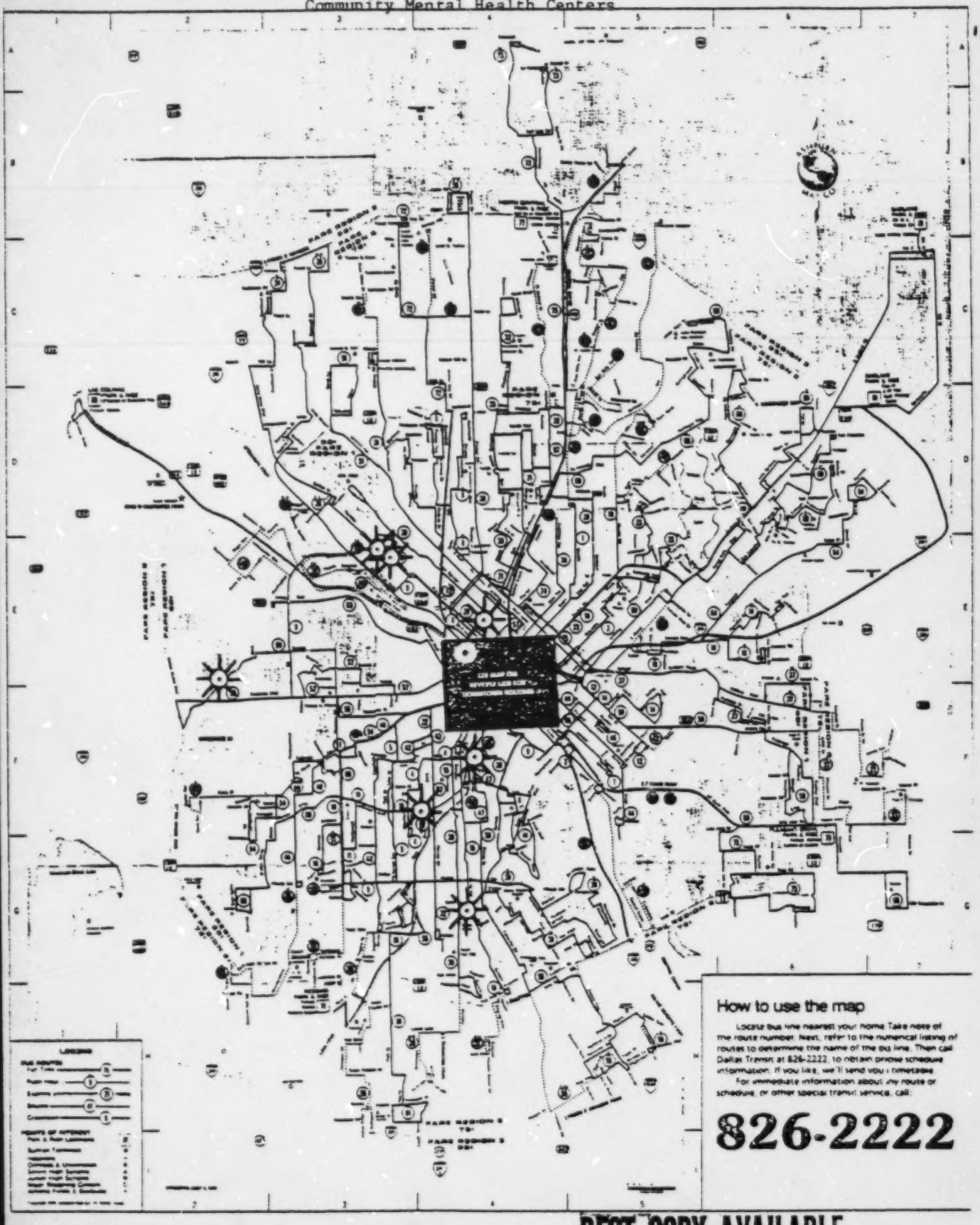
Because of this territoriality, it is important to call attention to the fact that some care has more than likely been taken to locate the CMHCs in those areas where the SL/SS population clusters, particularly when the SL/SS population of Dallas County is so small.

A glance at Map 35, the public bus lines in the city of Dallas, indicates that the center in CT 106 is right on a bus line, as is the one in CT 4.03. For those other census tracts that have large numbers of SL/SS residents in their boundaries, the bus lines go into the tracts quite regularly. CT 101, the second most populated tract, has bus routes that go into the neighborhood and can transport the residents quite easily to Bernal Street, where the CMHC is located. The rest of the census tracts have only small percentages of the total SL/SS population, yet the bus routes seem to penetrate well considering the size of the city as a whole.

It seems, from the evidence herein gathered, that the CMHCs in the county of Dallas are accessible to the clusters of the SL/SS populations. There is no conclusive, watertight evidence of this, as there are many extraneous variables to the association; but preliminary evidence indicates that accessibility would not be a problem to the SL/SS population clusters of Dallas County. It leads one to speculate that if there does exist a problem of underutilization by SL/SS people in the Dallas area, it is not because of the CMHCs' being inaccessible.

Map 35: The Dallas Transit System Bus Routes, 1979, and the Community Mental Health Centers




How to use the map
Locate bus line nearest your home. Take note of the route number. Next, refer to the numerical listing of routes to determine the name of the bus line. Then call Dallas Transit at 826-2222, to obtain precise schedule information. If you like, we'll send you a timetable.
For immediate information about any route or schedule, or other special transit service, call:
826-2222



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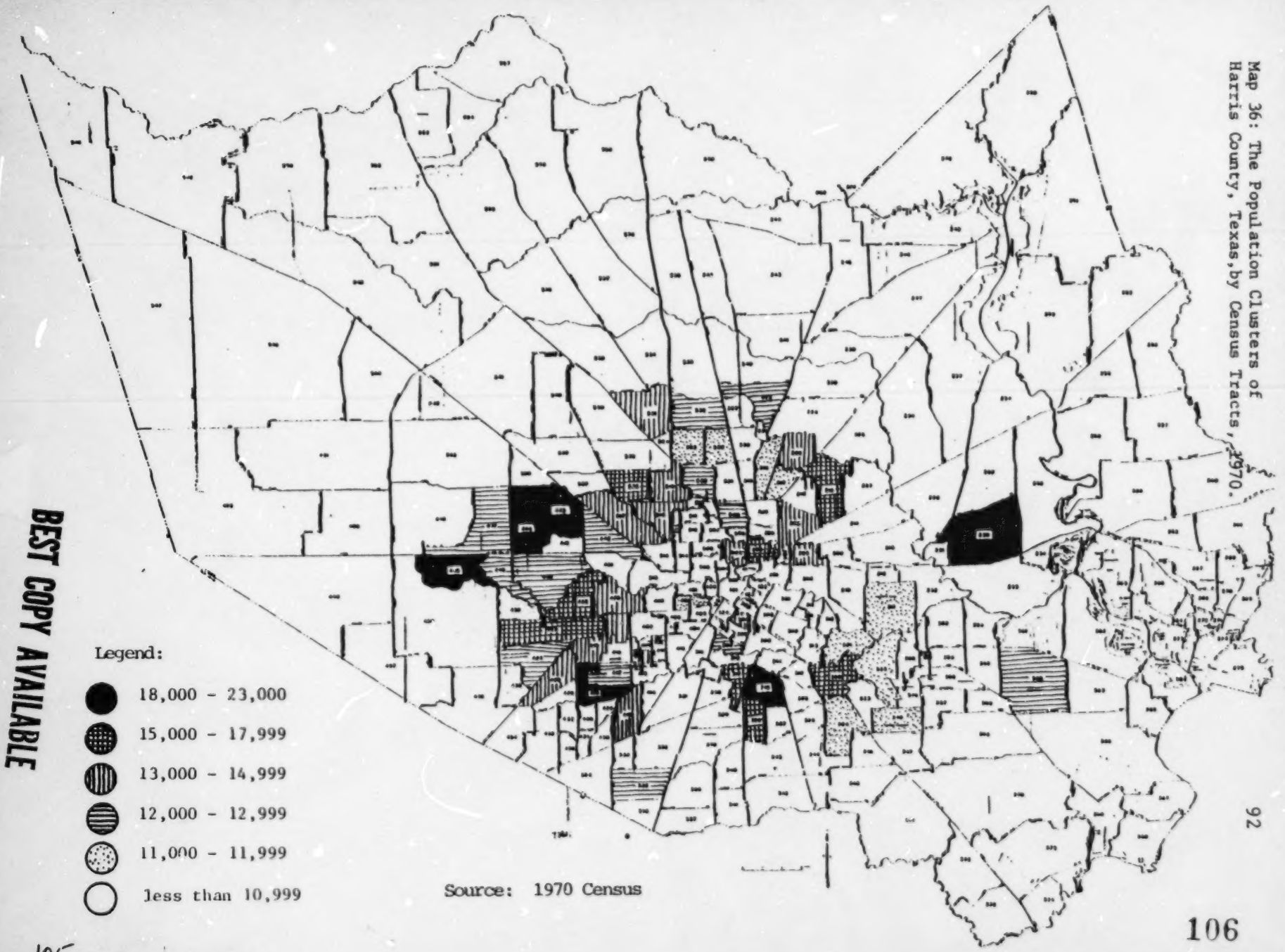
Houston. The largest city in the state of Texas, and one of the largest cities in the country, is Houston. The city of Houston proper had 1,232,740 residents in 1970, with 149,689 (12.1%) of these classified as SL/SS. The total SMSA of Houston had nearly 2 million people ten years ago and is undoubtedly quite larger by now. However, the catchment area for the Harris County Mental Health Authority is Harris County only, and this study will be limited to this catchment area boundary. The population of Harris County in 1970 was 1,741,912, of which 185,715 were SL/SS (10.7%).

Because of the density of the population of Harris County, it is difficult to present the total population clusters in a clear, distinct manner, but Map 36 can give one a rough idea of the distribution. In it, one can see that there are six census tracts that are densely populated, three of them very close to each other in the central west and near northwest portion of the city. The other three are rather well dispersed from the downtown area. If one were to draw imaginary lines directly north/south and east/west of the downtown area (CT 121), one would see that the quadrants are not equal population-wise. The western half of the city has far more residents than the eastern half. The northern half more than the southern. It follows then, that the northwestern quadrant of the city would have the heaviest population, which it does. However, one must recall that Harris County extends far beyond the clusters of the downtown area. The northwestern quadrant is also the largest. This should, therefore, be borne in mind when considering population density and city quadrants.




Map 36: The Population Clusters of Harris County, Texas, by Census Tracts, 1970.

Source: 1970 Census

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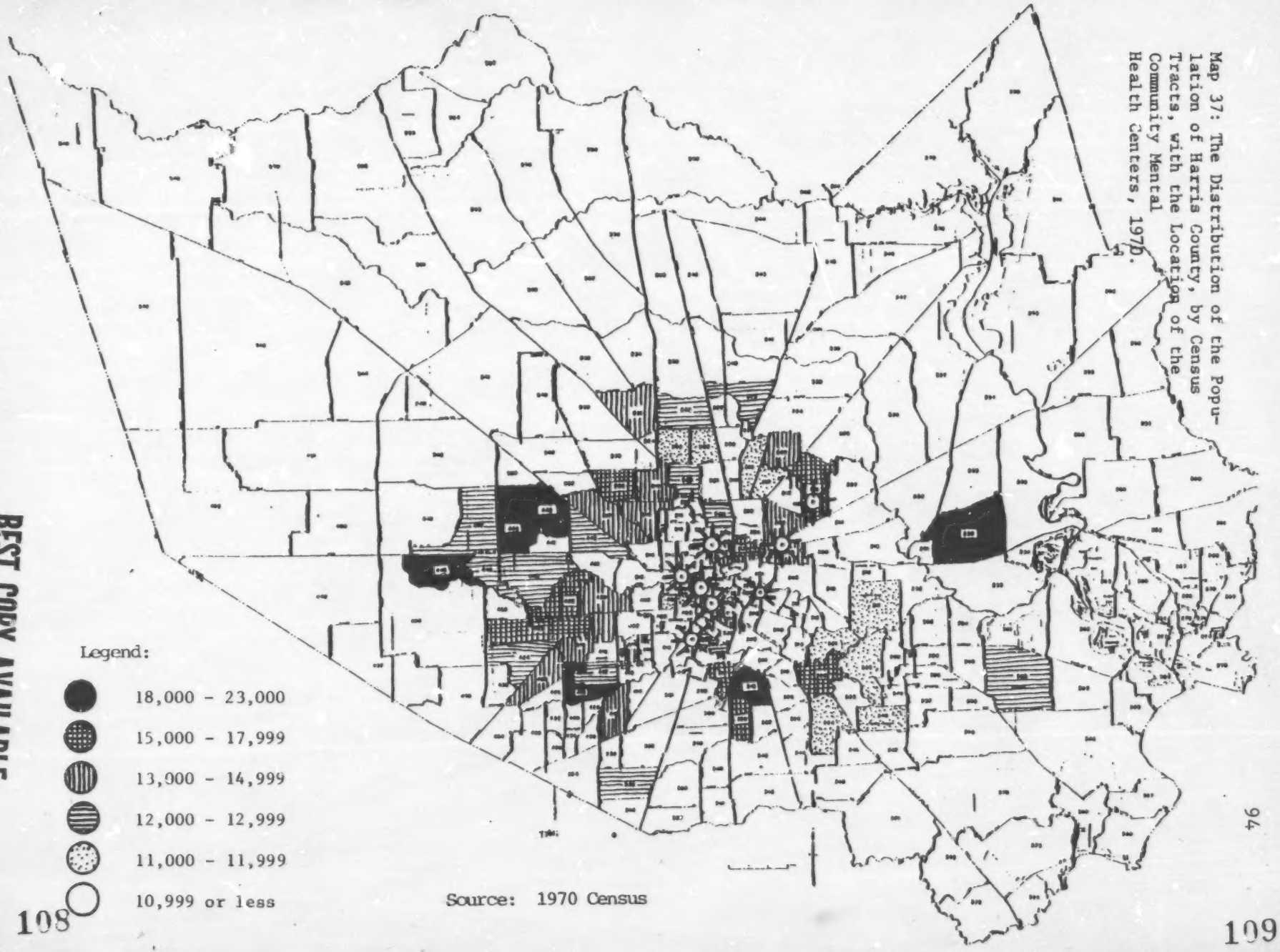
Nearly all the CMHCs are located in the downtown area. There are eight CMHCs that meet the criteria for this study's operational definition. None are located in those census tracts that are the most densely populated. There is, however, one center located in CT 215, which had nearly 17,000 residents in 1970. There are also two CMHCs located in tracts 503 and 203, which had between 13,000 and 14,999 residents, and one in CT 301, which had between 10,000 and 10,999. Otherwise, the centers are located in census tracts with less than 10,000 inhabitants -- in a city with well over fifty tracts of 10,000 plus inhabitants!

While on-paper-only reviews of the situation in Houston cannot fully evaluate CMHC accessibility (the author's goals are descriptive only), a safe conjecture would be that driving from one side of town to another in a county of nearly two million people can be slow, traffic-congested and troublesome. It is the experience of the author that in larger cities like New York, Los Angeles, etc., people often stay within one or two miles of their home for business, recreation, etc., avoiding the central downtown area whenever possible. Thus, for a person to commute from CT 230 to CT 203, where the CMHC lies, could involve considerable effort: so much so that anything that can be delayed or cancelled will be. This could result in unkept appointments.

A county of this size should have about eight to ten CMHCs to serve its residents. Map 37 indicates that Houston has eight community based, community-oriented CMHCs providing psychiatric services, per our definition. The problem is that the CMHCs have




Map 37: The Distribution of the Population of Harris County, by Census Tracts, with the Location of the Community Mental Health Centers, 1970.

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all been clumped together in the immediate downtown area. This may not lend itself to greater accessibility to the greatest number of people.

The one center that seems to provide the most accessibility is the one on Lynette, in CT 215, where a heavy concentration of people is found. It has previously been established that if a center is located outside a particular census tract, accessibility may not be as great due to the many extrinsic variables. While it is possible that a resourceful person may overcome the obstacles and achieve easy accessibility, it is not within the control of this research to measure client resourcefulness. Thus, it must be concluded from the evidence herein described that the people of Houston and Harris County have less accessibility to the CMHCs than would enhance their utilization.

The SL/SS population of Harris County is rather small, as previously mentioned. Map 38 indicates that the distribution of this population is small. As in previous cases, the map indicates the percentage of the total SL/SS distribution contained within each census tract. There is only one census tract that is quite heavily SL/SS, containing about 5% of the total population: this is CT 503. A glance back at Map 37 indicates that CT 503 is one of the more heavily populated tracts in the entire city. The second largest population clusters are in tracts 203 and 311. Census tracts 301 and 312 also have large percentages of the total Harris County SL/SS population. Other census tracts containing SL/SS populations (about two percent of

Map 38: The Distribution of the Spanish Language/Spanish Surname Population of Harris County, by Census Tracts, and the Location of the Community Mental Health Centers, 1970.

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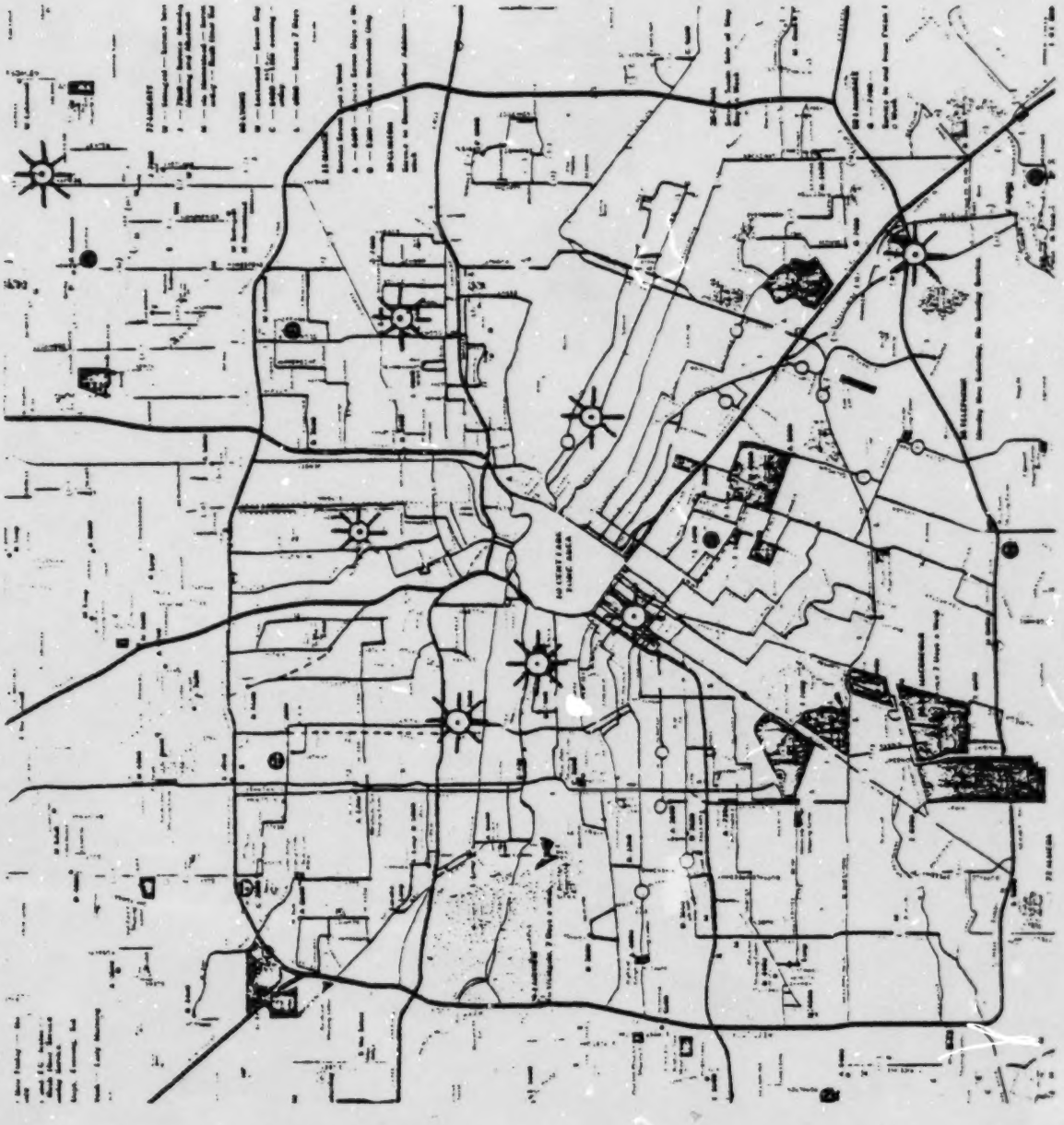
the total) are 122, 202, 223, 310, 321, 508 and 509. Of these, 223, 321 and 509 have more than 10,000 residents each. There are nine tracts in the immediate southeastern and east-central part of the city where about one-third of the total SL/SS population is clustered. The immediate northeastern edge has three census tracts that contain high percentages of the total SL/SS population. Finally, there are clusters of SL/SS residents scattered throughout the city in nearly all of the near downtown vicinity. Whosoever would say that there are no Mexican Americans in Houston should study this map and reconsider.

There are, admirably, three out of eight CMHCs located in census tracts that have large SL/SS populations: CT 503, CT 203 and CT 301. While better access could have been achieved by locating a CMHC in CT 321, placing one in CT 320 could provide almost as good an accessibility. In other words, four out of nine CMHCs are apparently accessible to the population clusters of the SL/SS population in Harris County.

Map 39 also indicates the catchment areas of the CMHCs in Harris County. The downtown and Houston proper area is divided into three catchment areas of two, three, and three CMHCs each. The other seven catchment areas reaching out to the limits of Harris County have a total of one CMHC between them. However, this is probably justified by the fact that it is the central city areas that most often are in need of public human services, whereas the suburbs may not require them as much. Again, based on the previous detailed concept of the indigents and ethnics

Map 39: Bus Routes of the Metropolitan Transit Authority of Houston, and the Community Mental Health Centers, 1979.



Source: Metropolitan Transit Authority of Houston

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requiring public services more so than the middle class suburbanites, this may be justified. The preference of the suburbanites may vary, but the indigent inner city dweller may have no option other than public services.

A review of the bus routes of the public transportation system for the city indicates that the CMHCs are all located either right on a bus line or within an eighth of a mile or so from a bus line. It seems that a brief quarter mile walk could be all that is required of those people that must use the bus to get to the CMHC. The two centers that are outside the Loop 610 circle are still close enough to a bus line to conclude that commuting there could pose only minor problems. Two centers are located very near a major hospital area (Jeff Davis Hospital and the Texas Medical Center) thus making transportation to and from the centers much easier. Generally speaking, then, that portion of the SL/SS population that must use the city buses in order to reach the CMHC should have little problem in doing so.

Houston, and Harris County in general, can be said to have services accessible to the SL/SS population clusters, based on the prima facie evidence and on-paper-only description of the resources. The CMHCs are centered in the inner city, close to the SL/SS population clusters, on the major bus routes or very near them so that if CMHC services are not being utilized by the SL/SS population of Harris County, the reason may exist in the acceptability of the services or in the several external elements that this accessibility description did not take into account.

Research Question Number Two, whether or not the mental health services at the CMHCs in the five major cities in Texas are accessible to the SL/SS population clusters, has a complex answer. Out of the five cities, four were found to have accessible services and one did not. Thus, the descriptive inquiry indicates that services are, in fact, accessible to the SL/SS population. However, the peculiar phenomenon of increasing services to those areas already served is noted in some of the cities that provide accessibility.

Table 1, Summary of the Findings of Accessibility of Mental Health Services to Spanish Language/Spanish Surname Population Clusters of the Five Major Cities of Texas, indicates the incidence of accessibility and the peculiar phenomenon. While it can be said that the cities are providing accessible services because of the central location of the CMHCs, it must be remembered that three out of five have moved from the central location into the other parts of town: but in so doing they have located in an Anglo, middle-class area rather than closer to the SL/SS neighborhood. In the case of San Antonio where they did locate in the SL/SS neighborhood, the public transportation system has not helped. Thus, the services may be accessible or they may not, depending on the point of view.

It must be concluded that services are accessible (four out of five), but there is an indication of a tendency to reinforce those areas already serviced and neglect the areas most in need.

Table 1: Summary of the Findings of Accessibility of Mental Health Services to Spanish Language/ Spanish Surnamed Population Clusters in the Five Major Cities of Texas.

| | ACCESS | PHENOMENUM |
|---|---|---|
| El Paso | yes | yes |
| Ft. Worth | yes | no* |
| San Antonio | no | yes |
| Dallas | yes | yes |
| Houston | yes | no* |

*"Yes" there is access and "no" there is no indication of the peculiar phenomenum of serving the already served is the most desirable situation.

## Chapter Three: Conclusions and Discussion

This research is exploratory and descriptive in design, intended to simply plot the locations of the CMHCs, the location of the SL/SS populations, to glance at the transportation between the two, and ask preliminary questions that should lead to further research.

The research question, as originally stated, was whether or not there is an association between ethnicity and accessibility to the CMHCs. This was divided into two Regional Research Questions. The first asked, "Are mental health services at the CMHCs throughout the state accessible to the majority of the SL/SS residing in that particular region of the state?", and the second asked, "Are mental health services at the CMHCs in the five major cities in Texas accessible to the SL/SS population clusters within those cities?" The "clusters" of the population were determined by the highest percentages of SL/SS residents in census tracts or state regions. The CMHCs were defined as those centers providing mental health services under Public Law 94-63, specifically under Section 201 of said law.

The evidence gathered for this description indicates a resounding "no" as the answer to the first question and the answer to the second question is a rather weak "yes." The first response is based on two major observations with three additional observations of a possible pattern. This possible pattern is one of separation of the CMHCs from those areas that are predominantly SL/SS. Based on prima facie evidence, intended to

instigate further research, the CMHCs throughout the state may, in effect, be taking measures to avoid those communities they were originally intended to serve under Public Law 94-63. Regarding the five major cities, this first glance indicates that those census tracts with large clusters of SL/SS populations have some accessibility to the CMHCs but this cannot be defended since in very few instances are the SL/SS population clusters and the CMHCs located within the same census tract. There are simply too many factors involved, especially when considering the riding of buses and the crossing of census tract borders, to be conclusive. The situation is further complicated by the fact that three out of five cities have located a CMHC in an area far removed from the people the law intended to serve, and closer to the more affluent communities. Thus, only a rather weak "yes" can be presented in response to the second question (in the case of Bexar County the response is a strong "no").

Because of the importance of location to utilization, this entire study has focused on the physical placement of the CMHCs. If the centers are in fact underutilized by the SL/SS people in their catchment areas, it could be because of the location of the center. If there is no evidence of inaccessibility of services, as in the case in some CMHCs in Texas, and yet these centers are underutilized, then the answer must be sought elsewhere. Underutilization is a problem that must be solved sooner or later if we are to provide adequate services to the large SL/SS population of Texas.

Overall, then, it can be said that those people who do not live in the larger metropolitan areas most likely do not have access to community mental health care. Those persons in the large metropolitan areas most likely do. In neither case has enough evidence been gathered to speak conclusively, but hopefully enough to generate further research.

Discussion. In making the previous observations, one cannot help but wonder what is the motivation or reason for the patterns. The original intent of the law was to meet the mental health needs of those people in the indigent, blighted areas, especially those of different ethnic or racial backgrounds; emphasis was placed on bilingualism. It was intended that those people most prone to suffer mental illness, VIZ., the poor, the immigrants, the dwellers of slums, etc., should be helped the most. Why then is there an indication of a tendency to place the CMHCs in areas quite removed from communities where these kinds of people reside? Probably a good place to start an inquiry into the current situation is to glance at the law that most affects the location of the CMHCs: Public Law 88-164, Title II, THE CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS.

Public Law 88-164 called for all the states to come up with a statewide mental health plan and the centers would then be constructed to carry out that plan. This law called for the provisions of several types and kinds of services, one of which was for overnight stays when necessary. This led to the requirement that the center be "associated" with a general hospital.

The result was that those areas that already had services available (even if no more than a psychiatric ward in a general hospital) were the only ones that could meet the requirement! Thus, the program discriminated against poverty areas, and the communities that needed services the least got them most. While this alone could not account for the present phenomenon in Texas, it could contribute. Before this can be settled, a detailed analysis of Title II of Public Law 88-164 will be necessary.

Another possible reason for the "pattern" could be that Public Law 94-63 calls for the provision of services in two languages if a large percentage of the population speaks little or no English. Hence, the emphasis on bilingualism. This, of course, is intended to make services more acceptable to the non-English-speaking groups. Because of this state's history of discrimination in the institutions of higher learning, there is oftentimes a shortage of bilingual professionals at the local level. Therefore, it would be easier to provide services to English-speaking clients since English-speaking professionals are easier to find. This could lead to the placement of the centers in a predominantly English-speaking area, thus relieving the center of the onus of bilingualism.

Finally, and probably most importantly, there are loopholes in many, many laws that can be found by those who would discriminate against certain groups. While there is no clear indication of discrimination thus far in this research, Texas' history of segregation and discrimination cannot be overlooked

when considering the reasons for a non-English-speaking ethnic group being underserved. Discrimination could be much harder to prove if the policy is being carried out and the law is being fulfilled.

In conclusion, the author has brought about a preliminary description of the mental health services to the SL/SS people of Texas. Certain peculiar patterns tend to appear and several curious phenomena have been observed. This has led to the posing of several questions that beg answers before meaningful changes can be made in the services of the CMHCs to the SL/SS. A few explanations have been suggested as to why the present circumstances exist. Undoubtedly, no single explanation in and of itself can answer the questions, but most likely the causes of the present situation are multiple. This, in turn, will make the solution more difficult. No doubt the research that this study may generate will lead us further in that direction.

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APPENDIX A

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